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## **"Putting salt on the wound": Understanding the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Britain**

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Title: "Putting salt on the wound": Understanding the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK.

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**Abstract:**

**Objectives:** This research documents the experiences of people with Somali heritage with FGM-safeguarding services in healthcare, providing important new evidence regarding the extent to which such services are considered appropriate by the people who encounter them.

**Design:** Six focus groups conducted with ethnic Somalis living in Bristol, during the summer of 2018, divided by gender and whether people had experienced FGM-safeguarding as adults or children.

**Setting:** Participants experienced FGM-safeguarding in primary and secondary care.

**Participants:** 30 people (21 women and 9 men), identified either through local organisations or snowball sampling. All participants were of Somali heritage and aged over 18.

**Results:** Government priorities to support those who have experienced female genital cutting/mutilation (FGC/M)<sup>i</sup> are being undermined by their own approaches to protect those considered at risk. Participants in every focus group argued that approaches to FGM-safeguarding were based on outdated stereotypes and inaccurate evidence which encouraged health and other service providers to see every Somali parent as a potential perpetrator of FGC/M. Female participants described the ways in which providers in a range of healthcare settings, including A&E, antenatal care and general practice, were ‘fixated’ with FGC/M and ignored both their health needs and their experience as victims themselves. Participants felt stigmatised and traumatised by their experience of FGM-safeguarding in healthcare. This undermined their trust in health services, producing a reticence to seek care, treatment delays and reliance on alternative sources of care.

Associated recommendations include developing more accurate evidence of risk, more appropriate education for healthcare providers and more collaborative approaches to FGM-safeguarding.

**Conclusions:** All the participants involved in this study are committed to the eradication of FGC/M. But the statutory approaches currently adopted to enable this are considered ill-conceived, unnecessarily heavy-handed and ultimately detrimental to this. Recognising these common aims can enable the development of services better able to protect and support those at risk of FGC/M in ways which are culturally competent and sensitive.

### Strengths and limitations of the study

- This is the first study which evaluates the impact on FGM-safeguarding in healthcare on users in the UK.
- The qualitative approaches adopted offer particular insights into the experiences and impact of these services.
- The study involves those who engage with FGM-safeguarding services in a range of ways, as parents, children, significant local stakeholders including those involved in anti-FGM education and campaigning.
- Further research needs to examine whether the attitudes expressed here show consistency other people with Somali heritage living elsewhere in the UK and beyond, and those from other FGC/M-affected groups.
- Exploring the experiences of health providers with the provision of FGM-safeguarding policy would also be informative for identifying opportunities to improve services.

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**Introduction**

Female Genital Cutting/Mutilation (FGC/M)<sup>i</sup> is considered a ‘global concern’,<sup>2</sup> affecting populations from a number of African, Asian and Middle Eastern societies. Across Europe, policy responses to FGC/M have tended to criminalise those engaging in the practice.<sup>3,4</sup> In the UK, it is recognised that those living with, or at risk of, FGC/M need to be provided with sensitive and compassionate care. Patient-centred healthcare responses can ‘optimise future reproductive and sexual function, psychological health and quality of life’, while also providing an ‘effective safeguarding response’ to identify and protect those at risk.<sup>5</sup> Unfortunately, in spite of these positive aims, there are concerns that current approaches to FGM-safeguarding may instead work to stigmatise those it aims to support, directly weakening patients’ trust in health services.<sup>6</sup> To date, no academic research conducted in the UK has effectively explored this.

UK politicians and media sources have repeatedly claimed that ‘tens of thousands of girls’ living in the UK are at risk of FGM/C<sup>7-9</sup>, although the evidence available to support these statements is problematic.<sup>10</sup> The Serious Crime Act 2015 mandates that professionals in health, social care and education report to the police all girls aged under 18 who disclose or have physical evidence of FGC/M.<sup>ii,12</sup> Reporting was also introduced for monitoring purposes in general practice and mental health and acute trusts. This has been supported by the introduction of the FGM Enhanced Dataset, which requires NHS practitioners to record detailed information about FGC/M within the patient population,<sup>13,14</sup> and an information sharing system which flags the summary care records of all baby girls born to mothers who have undergone FGC/M.

Whilst these policies appear to be well-intended, concerns have been voiced regarding the evidence underpinning the policies, as well as their effectiveness.<sup>6,15</sup> For example, such policies assume a direct

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<sup>i</sup> Whilst the term ‘female genital mutilation’ (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genitally mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi & Earp (2019)<sup>1</sup>. The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, scholars prefer the term, female genital cutting (FGC).

<sup>ii</sup> The WHO definition of FGM includes a range of procedures including: clitoridectomy – the partial removal of the clitoris or prepuce (type 1); excision - the partial removal of the clitoris and labia minora (type 2); infibulation – the narrowing of the vaginal opening (type 3) and; any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4 therefore includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of Type 1 and 2 also mention ‘total’ clitoral removal, but Abdulcadir et al argue that this relies on anatomically incorrect understandings of the nature of the clitoris.<sup>11</sup>

link between historical cases of FGC/M in the older, migrant generation and the risk to UK-born children despite their very different cultural environments.<sup>10</sup> There is mounting evidence that the scale of risk to UK-based children is significantly lower than these approaches presume<sup>16,17</sup>, with reduced levels of support for FGC/M particularly, but not only, among migrants and drastically fewer incidents of the most serious forms of the practice.<sup>6,18-35</sup> As Creighton and Bewley argue, “gynaecologists would see more acute complications were significant numbers really happening ‘every hour of every day’ as suggested by the 2015 Home Affairs Committee (House of Commons 2016)”.<sup>36</sup>

Identifying the scale of this risk of further complicated by non-response. By 2019, only 2% of GP practices had submitted any information to the FGM Enhanced dataset.<sup>37</sup> The reasons for this are unclear. Official explanations suggest a potential lack of awareness of reporting requirements or practical issues affecting submissions, as well as the low levels of FGC/M in certain areas.<sup>38</sup> However, we suggest that concerns about the impact of FGM-safeguarding and monitoring in healthcare on patients may also explain this. In their 2019 *BMJ* editorial, Creighton and colleagues<sup>6</sup> expressed concerns regarding the “emotional and financial weight” placed on families experiencing FGM-safeguarding. These concerns are confirmed by empirical evidence of the negative consequences of FGM-safeguarding and monitoring policies in Sweden,<sup>39</sup> which “have ramifications that are invasive and sometimes even traumatising for the girls involved... [and] may negatively influence the sexual health and rights of [the] target group.” To date, no academic study has explored these issues in the UK. This paper responds to this gap, using evidence from focus groups with Somali people living in Bristol. International statistics, including those from the World Health Organisation (WHO) and UNICEF, routinely state a 98% FGC/M prevalence rate among the Somali population, the highest in the world.<sup>40,41</sup> Consequently, those with Somali heritage have received particular scrutiny in national and international debates on FGC/M and offer a valuable focus for this study.

## Methods

The study involved six focus groups which collected data on the perspectives of Somali families with experience of FGM-safeguarding in Bristol, in the summer of 2018. Participants were identified using the research team’s existing contacts with a range of organisations run by and/or representing people with Somali heritage living in Bristol and others contacted through snowball sampling. This included those who experienced FGM-safeguarding as parents, children, significant local stakeholders and those more active as anti-FGM campaigners and those involved in the development the ‘Bristol

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Model’<sup>iii</sup>. While we were approached to conduct the research by people concerned by the impact of current approaches to FGM-safeguarding in the city, we ensured that we also recruited individuals who might not be so strongly motivated to report negative experiences. This approach enabled valuable insights into the experiences of individual Somali families and also those of the Bristol Somali population more generally.

All participants were aged 18 or over. Focus groups were divided by age and gender to reflect the potentially varying perspectives of those who were children at the time of safeguarding and those who were adults, and participants’ stated preferences for gender-specific groups. Focus groups 1,2 and 3 included older women who described experiences of FGM-safeguarding as adults. Focus groups 4 and 5 included older men. Focus group 6 included younger women, who were children when their experiences of FGM-safeguarding occurred. All participants signed informed consent before taking part. Focus groups were conducted in the university and in community settings familiar to the participants and were recorded and transcribed by the research team. Translation was provided during focus groups by local Somali people when required. A total of thirty participants (twenty-one women and nine men) were interviewed. Ethical approval for the study was obtained from the University of Bristol Ethics Committee (Reference:K260618). While not involving medical research, this project complies with the relevant requirements of the World Medical Association Helsinki Declaration.

The research aimed to explore participants’ perspectives regarding their experience of FGM-safeguarding in different domains – health care, education, via home visits from social services and the police, in courts and at borders – and the positive and negative implications of these. Discussions also considered the direct impact of FGM-safeguarding on service engagement, and on relationships within families, the local Somali community and with wider British society. This paper focuses particularly on experiences in healthcare settings. Further details of the research are available in Karlsen et al.<sup>44</sup> Thematic analysis<sup>45</sup> identified several ways in which approaches designed to support those with experience and protect those at risk of FGC/M directly undermine the provision of effective health care. The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no important aspects of the study have been omitted; and that any discrepancies from the study as originally planned have been explained.

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<sup>iii</sup> Bristol has a long traditional of pioneering work towards the development of effective FGM-safeguarding policy. Collaboration between local policy-makers, professionals from education, health, social services and the police and members of the local Somali community led to the development of the ‘Bristol Model’ of FGM-safeguarding, which was subsequently incorporated into approaches across the UK.<sup>42,43</sup>

Members of the public were involved at all stages of the research process. The research was motivated by a request from the public, and the project aims and methodology were developed in collaboration, building on mutual recognition of both the preferences of local partners and the requirements of ethical, independent research. People with a Somali heritage living in Bristol were instrumental in the identification of study participants and decisions regarding the conduct of the focus groups and provided practical support with the provision of childcare, translation and refreshments. All participants were invited to a presentation and discussion of findings with the research team prior to the publication of the report to confirm accuracy and support the maintenance of a sense of partners' ownership over the project. This approach was instrumental for minimising the impact of researcher characteristics.

## Results

FGM-safeguarding in healthcare settings was predominantly experienced by women, often in routine appointments with midwives, GPs and health visitors, although there were notable examples of FGM-safeguarding experienced in Accident and Emergency departments. While men discussed at length issues with FGM-safeguarding (both generally, and in relation to specific contexts), there was less discussion of issues with healthcare in these focus groups. This is likely to be explained by the particular ways in which Somali women engage with health care, on their own behalf when pregnant and also on behalf of their children. It is not possible to assess the frequency with which these issues occurred with these data, but certain perspectives were reiterated across multiple groups. While some participants' experiences were considered less problematic, Somali women in all focus groups discussed the negative treatment which occurred repeatedly and in each of these healthcare settings. It was considered "normal" for the mid-wife to talk about FGC/M "everyday" (at every antenatal appointment). Women in each of the focus groups explained that that an awareness that other medical concerns, particularly those relating to a woman or girl's genital area or stomach, were reacted in more extreme ways by healthcare practitioners when involving Somali people.

Several themes were evident. Most simply, most participants objected to being asked about their experiences of FGC/M. This objection was aggravated by the often-repeated nature of this questioning – across multiple or within single encounters – which was seen to ignore and even exacerbate the traumatic nature of FGC/M itself. These experiences were further worsened by approaches considered culturally incompetent and insensitive to, as well as ignorant of, the facts of FGC/M. Approaches to FGM-safeguarding were felt to rely on and reinforce outdated stereotypes of the Somali community, which encouraged suspicion from health providers and directly contributed to the

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stigmatisation and victimisation of Somali people in healthcare and more widely. All-in-all, participants argued that the focus on getting “results” for the NHS Enhanced Dataset meant that the health needs of the patient and their family were de-prioritised. The quality of the healthcare provided to Somali families had diminished as a result. Participants felt undermined and distrusted by professionals expected to care for their health and that of their families. Not surprisingly, this had negative consequences for their trust in and engagement with health services.

The re-traumatisation of FGC/M-affected women through invasive and insensitive questioning

Many of the women in the focus groups who had experienced FGC/M said it was something that they wished to forget. As well as the physical and psychological consequences of the experience, it had also damaged relationships within families which it had taken time to repair. The majority of participants felt that being asked about their experiences of FGC/M was in itself intrusive and upsetting, with one woman stating: “This is a very private matter. You can’t just ask me what it’s like inside my legs.” Participants objected to being asked about FGC/M when this was considered irrelevant to the health concern. But even where establishing FGC/M status might be pertinent, such as during pregnancy, participants felt that such questioning was often insensitive. That policy required these questions to be asked repeatedly aggravated women, even when they were asked sensitively. One of the issues raised most often in the focus groups was the failure of health practitioners to acknowledge that FGM-safeguarding had already been undertaken and that this information was therefore already available to them:

*“When I go to the GP, they ask me again and again, did you do that [FGC/M]? I told the GP, please write down on your computer, I don’t want to do that [FGC/M] and so please don’t ask me any more questions. I hate to hear these kinds of questions.” (Focus Group 1)*

Where participants described less distressing experiences with FGM-safeguarding in health settings, encounters had been friendly and open and participants recognised that safeguarding had been performed out of a genuine desire to protect them. This young women recounted a conversation with her GP before a holiday and described the differences between this encounter and others she had experienced:

*“She wasn’t saying it in a kinda aggressive way, she was saying it as if it was a normal chat. She goes, ‘I know this is a really silly questions to ask’ but she’s like, ‘I’ve gotta ask it’. She just said, ‘There isn’t any chance of you having FGM done [while you’re on holiday]?’ I goes, ‘No, there isn’t’. She goes, ‘That’s fine, then.’ If they were a bit more sensitive and they just kinda said, in*

*a polite way, 'I don't mean to be rude or insensitive but is there any chance that your daughter could be at risk of FGM? No offense to you or anything', and the parent says, 'No', then...there's no need to get the police involved." (Focus Group 6)*

However, participants described numerous examples where health professionals had not achieved this:

*"Did you have the FGM?" she [midwife] asked. It was like an interview. I was quite shocked.... "You have to answer this question," she told me...She was desperate to fill in this form. I was uncomfortable... It frightened me really." (Focus Group 1)*

Participants also described how these difficult conversations could occur in quite public locations, such as *"behind curtains, other people could hear...dignity kind of went out of the window"*. This reliance on an 'interview' style, which followed a *"form"* or *"script"*, was explained as a consequence of a lack of understanding of FGC/M among health professionals which failed to engage with the knowledge or concerns of their patients: *"They don't know what they are talking about. It's insulting. You feel embarrassed and attacked."* People were embarrassed by the questions, insulted by the fact that health professionals knew so little about an issue they were supposedly educating them about (and indeed, often less than the participants themselves) and attacked by the assumptions about their culture which underpinned these policies and approaches. This apparent lack of care and 'interview' style of questioning undermined this participant's trust and sense of security in her relationship with her midwife, which led her to question her need for antenatal care: *"I told her that I didn't need a midwife like this"*.

Approaches to FGM-safeguarding in healthcare were argued to not only ignore but actually risk exacerbating the trauma associated with the experience of FGC/M itself. Our evidence suggests that these traumatising effects are related to:

- the ways in which patients are forced to answer questions about their experiences of FGC/M, even when they explicitly express a wish not to;
- the ways in which victims of FGC/M are forced to (repeatedly) disclose details of their experience to medical staff, approaches which are generally considered inappropriate for victims of (other forms of) child abuse; and
- the insensitive approaches which fail to acknowledge the potential psychological and physical impacts of experience of FGC/M, despite these being the premise on which these policies are deemed necessary.

Taken together, these issues were considered to risk inflicting significant damage on the welfare of individuals, particularly those with experience of FGC/M:

*“The parents who had it done, they are traumatised. [...] To ask mothers who are traumatised [about FGC/M] over and over and over again. You’re putting salt on that wound, you’re making it fresh again.” (Focus Group 1)*

The impact of outdated stereotypes

Participants commented that the evidence underpinning approaches to FGM-safeguarding drew on outdated assumptions about Somali culture and the positive attitudes of people with Somali heritage towards FGC/M:

*“The minute you say there is a problem, because [of] who you are, the first thing the GP will look at you, if you mention anything about that [genital] area, any healthcare setting, they feel obliged to ask you [about FGC/M].” (Focus Group 2)*

None of the participants in our study claimed that they supported FGC/M and they all agreed that it was a practice that children should be protected from. Participants in all groups were adamant that these attitudes to FGC/M were common among British Somalis and were frustrated that this was not acknowledged in FGM-safeguarding policy: *“Young mothers, born here, do not have FGM”*. It was argued that these attitudes had been encouraged by migration to Britain, to a *“different [FGC/M] environment”*. People also described the significant impact of Bristol Somali-led anti-FGC/M initiatives on awareness of the nature and problems of FGC/M in Britain. Participants reflected that attitudes to FGC/M were changing in Somalia/Somaliland, such that even these statistics were problematic: *“A hundred years ago, this country had a different culture from today. Are the people still living in the same way? They modernised. So, in Somalia, we too modernised.”* Participants argued that they were *“trying to find our identity as British Somalis, and we don’t want FGM to be part of that”*. But approaches to FGM-safeguarding were believed to directly undermine these aims:

*“Even though, as a community, we want to move away from this practice [FGC/M], again, to be slapped across the face with it...even if communities stop practicing it, they will still be stigmatised and labelled by it, and it kind of undermines the progress that we’ve made” (Focus Group 3)*

These persistent stereotypes encouraged health practitioners to treat their patients with suspicion, misinterpreting behaviour considered normal (both for Somalis and others) as indicative of potential

FGC/M risk: “[My daughter] was one of those shy kids, she wouldn’t take her clothes off in front of anybody. And the nurse kept saying to her “Do you want your mum to leave?” Approaches to FGM-safeguarding encouraged a sense of Somali parents as incompetent and prone to criminal activity: “my mum got taken for an idiot or that she was unworthy of being trusted as a parent”. Parents described how they felt forced to prove their innocence in response to the unsubstantiated negative reactions of healthcare providers. Parents were asked repeatedly about their plans to arrange FGC/M for their daughters. This was interpreted as an attempt by health practitioners to ‘catch people out’ and admit their dishonest and criminal intentions. Not surprisingly, this was considered extremely disrespectful:

*“And my mum was like, “No... no-one in my family’s had it done, I don’t know where you got this information from” and she (Nurse) kept on badgering my mum, as if she was trying to get information. Like, I know when someone tries to be manipulative, as a professional, it’s very easy, she kept asking my mum... It was very patronizing, and my mum was getting frustrated because... you know, when you see your child’s in pain and no-one’s helping them, so the more frustrated my mum got, the more angry and the more guilty it made her look...Everything got brushed aside. It was just fixated on making my mum look guilty.”*

*(Focus Group 6)*

A failure to acknowledge potential changes in attitudes towards FGC/M among affected groups can exaggerate a perceived risk and encourage practitioners to view their patients with suspicion, undermining the provision of sensitive and culturally competent care. This directly contributed to participants’ loss of trust in their health providers and sense of exclusion from wider society.

### Loss of trust in health services

There was a strong sense from across the focus groups that the health needs of Somali families were being overlooked in efforts to collect data on FGC/M: “Before they cared about your health and how the child was feeling. Now it’s just FGM.” This sense of the de-prioritisation of a patient’s health needs was evident in a range of healthcare settings, including in general practice and midwifery care, as well as acute A&E services. Even those with potentially serious symptoms could have their health needs overlooked in efforts to conduct FGM-safeguarding:

*“Instead of the nurse trying to figure out why I was in such pain – you know, the usual procedures, bloods, blood pressure, all of that – she [the A&E Nurse] skipped all those steps*

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3 *and directly, she was like to my mum, "Have you done FGM to your daughter?... I think it's*  
4 *quite dangerous when...if a nurse or a doctor hasn't been given enough training or [has]*  
5 *enough awareness on the topic to the point where they might misdiagnose the patient"*  
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8 *(Focus Group 6)*  
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10 Participants described how the Somali community – through their own educational initiatives – had  
11 become more aware of the health implications of living with FGC/M. But, even here, the focus of  
12 health providers on FGM-safeguarding and data collection meant that the health needs of women  
13 could be ignored:  
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18 *"Now there is a fear [that] she [the woman with FGC/M] will lose the child, she will have*  
19 *health problems, complications. [Somali] People are now more aware of the [long-term]*  
20 *health issues [of FGC/M]. How do we get our service providers here to understand this?"*  
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22 *(Focus Group 4)*  
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25 Such evidence further highlights the limitations of assumptions regarding the educational potential of  
26 such health provider engagement.  
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31 Participants described ways in which experiences of FGM-safeguarding had directly contributed to a  
32 loss of *"confidence in the health service"*. Inappropriate or insensitive healthcare generated an on-  
33 going concern among families:  
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36 *"We are just very worried now. I've got a daughter who is nearly 12, if anything should*  
37 *happen to her, to her privates, if she gets an infection, the first thing that comes in my*  
38 *mind is this situation [FGM-safeguarding]. [...] It's very stressful, it keeps coming back. The*  
39 *first thing that comes in my mind is that the doctor will ask you this question."* *(Focus*  
40 *Group 1)*  
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45 There is a tangible fear relating to parents' awareness of their inability to protect their children from  
46 a system perceived to be designed to harm people. This service disengagement led some participants  
47 to rely more heavily on unregulated or unorthodox medical and non-medical alternatives, while others  
48 described engaging with health services with more reluctance and at a later stage: potentially risking  
49 their health and increasing the need for more intensive medical responses. Importantly, participants  
50 reflected that the problem with FGM-safeguarding in health care, and more generally, was as much  
51 one of legislated policy as its implementation. Health practitioners were often argued to have no  
52 choice, that they were just 'doing their job': *"they feel obliged to ask you [about FGC/M] because they*  
53 *don't want to get in trouble"*. But while this encouraged a little sympathy for health providers, it also  
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discouraged hope for future improvement.

### Policy recommendations

Participants in several focus groups recognised the positive intentions of FGM-safeguarding and all acknowledged the need to protect children at risk. However, approaches adopted to achieve this were believed to be unjustifiably aggressive and counter-productive, to the extent that *"Safeguarding policies [had] exacerbated and exaggerated the situation"* rather than resolving it: *"I think the safeguarding policy is fantastic, [but] you have to take precautions because...the end goal is to stop this happening, but if we are to stop this happening, we need to think about the process. If we are offending people, and to a certain extent, violating people [we will be unsuccessful]"* (Focus Group 6). The introduction of FGM-safeguarding was seen to have directly contributed to a loss of empathy in the provision of healthcare to not only individual Somali families, but the entire Somali population:

*"People are more result-orientated than [interested in] looking at the feeling and perspective of the community and parents who are involved, or even the young child who is involved. Being result-focused, it is more difficult to be empathetic with someone."*  
(Focus Group 4)

Participants argued that there were problems with the evidence underpinning these policies as well as with their implementation. People were concerned that the statistics collected as part of the FGM Enhanced Dataset, which focus on women who had experienced FGC/M as children when living outside the UK, could be *"misuse[d]"* to inflate perceptions of the scale of the FGC/M risk posed to young girls living in the UK. Participants also considered it unhelpful that the statistics collected included those for *"piercing"*, *"cosmetic [surgery]"* and *"different [less invasive] categories [of FGC/M]"*, which were less relevant for addressing what they considered to be the most pressing *"FGM issue"*. This amalgamation could also be used by the media and others to exaggerate the prevalence of FGC/M and further stigmatise the Somali population without justification. In order to get *"more accurate and precise statistics... that are not so biased"*, there was a need to *"hear the views of the young people who were born in the West."*

While some participants acknowledged the contribution of Somali people to the development of approaches to FGM-safeguarding approaches in Bristol (although attitudes regarding the longer-term success of this collaboration varied), others felt that the engagement of policy-makers and practitioners with Somali people in Bristol had been less than comprehensive. Recommendations for

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improving services therefore emphasised the need for more inclusive approaches, involving different FGC/M-affected groups, in the development and implementation of safeguarding services, with “a proper consultation” to develop “policies which we are part of”.

A constant theme among participants was the significant need to improve the education received by professionals involved in the provision of statutory FGM-safeguarding. Education was required to ensure that staff could identify and describe forms of FGC/M, and better support those who had experienced it. ‘FGM Standards for Training Healthcare Professionals’ were published in 2018,<sup>46</sup> and built on the earlier safeguarding curriculum. Training on FGC/M type is included for some, but not all, staff. Participants also described a need for more awareness of the potentially traumatic effects of FGM-safeguarding itself:

*“You gotta think about the child, as well. Imagine having to go into a hospital or doctor and get examined. Just imagine how uncomfortable you’re feeling when someone’s like searching your private parts. That’s almost like a violation to you because that’s **your** private parts... ..we have to be very considerate of the situation” (Focus group 6)*

While current guidelines expect those conducting genital examinations of children to be considerate of appropriate approaches, it is unclear whether this will be sufficient to address this. Professionals also needed training to ensure that information gathered on people’s FGC/M experience, was gathered sensitively, to avoid it being experienced as an “interrogation”:

*“It’s a relevant thing to ask [but] it’s a very sensitive thing to ask so the wording around it and how you actually approach a parent...it needs to be sorted out otherwise I feel like a lot of Somali parents are going to ... take it as an offence, instead of a general question. When you are questioning a mother about ‘are you going to send your child over there to get FGM done?’, it can come across as a threat against her culture, against her parenting. It’s like asking any parent, ‘Are you going to starve your child?’, [the reaction is] ‘Are you mocking my parenting? Why would I do that?’ That’s why I think a lot of people are very defensive”. (Focus Group 6).*

More general training to provide sensitive care and enable health providers to “be sensitive to that person’s culture” was required. More specifically, recognising “the historical [pre-migration FGC/M] context” and how that might have changed over time would also enable them “not to automatically assume that you’re guilty of this crime”. Participants argued that not only were Somali people not supportive of FGC/M, but they now understood many of the health implications of aspects of the practice. This identified need was not recognised by health providers, and is not acknowledged in training guidelines.

Participants were particularly frustrated with the ways in which a failure to acknowledge these cultural changes encouraged mothers' experiences of FGC/M to be used as indicators of risk for their children, which unfairly framed them as potential criminals rather than victims and drew attention away from their healthcare needs. Acknowledging that not only Somali cultures were associated with FGC/M would help address the particular ways in which those with Somali heritage were "targeted". A Public Health England FGM training video which "shows that it's not just one ethnic" group was highlighted as making a positive contribution to this realisation. Developing knowledge of these "facts" was considered important for restoring a "belief in the system".

A more collaborative approach in healthcare and more generally would enable more successful interventions within families and cultural changes that could eventually lead to the elimination of FGC/M. This improved communication should also extend to establishing more effective means of responding to negative treatment: "I think my mum did try and put in a complaint [to the NHS] but then she left it after a while because she said, "it's not worth it if somebody's going to be uneducated. There's nothing I can do about it". More sensitive approaches were argued to have the potential to engage families around FGC/M while minimising the harm associated with current practices, including the sense of fear, stigmatisation, criminalisation and (re)traumatisation which is evident in current approaches:

*"If I was approached in a correct manner, I would obviously cooperate, but if I was approached in a manner where I felt targeted, harassed, I couldn't cooperate at all."*  
(Focus Group 6)

## Discussion

Global concerns regarding FGC/M and strategies developed to safeguard potential victims are premised on the potentially traumatic emotional and physical effects of these practices.<sup>47</sup> But while the need to protect potential victims is of the utmost importance, evidence from this research - while limited in its scale and generalisability - suggests that current approaches to this protection risk traumatising families, and re-traumatising child victims of FGC/M in adulthood. Such experiences undermine relationships between families and their care providers and the likelihood of effective safeguarding or indeed healthcare being provided in both FGC/M-related contexts and others. This research replicates that from Sweden, which also presents the traumatising impact of policies which are "meaning well while doing harm".<sup>39</sup>

Government guidelines suggest that "adhering to key standards will enable professionals to hold

conversations [on FGC/M] in a sensitive and appropriate way. These include:

- making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity;
- working with others to protect and promote the health and well-being of those in their care, their families and carers and the wider community; and
- being open and honest, acting with integrity and upholding the reputation of the profession.”<sup>48</sup>

The evidence from this research suggests that this is not happening universally. Our participants describe the ways in which their own needs and opinions were ignored and their dignity and respect undermined by a service ‘fixated’ by gathering information on FGC/M, even at times using practices considered ‘manipulative’ to achieve this. Participants’ experiences of FGM-safeguarding in healthcare directly disrupted their sense of what could be expected of their healthcare providers and, as a consequence, their trust in these services. Indeed, rather than working with families and carers, professionals were identified as sometimes working to directly undermine these relationships. We have identified a number of specific opportunities to improve services, which concur with international research on this topic.<sup>49-51</sup> It is imperative that policy-makers and healthcare providers recognise and respond to the potentially sensitive nature of FGM-safeguarding, for those with experience of FGC/M but also more generally. There is also a need to be mindful of the changing attitudes and needs of FGC/M-affected groups, and the ways in which incorrect assumptions regarding these have encouraged policies and approaches which are counter-productive and stigmatising. There is a clear need both to protect those at risk of FGC/M and support those living with its consequences and respond to evidence from this research that a perceived risk to an (often unborn) child is overriding the care of her mother, family and wider community. Further research must be conducted to determine whether similar experiences are reported amongst those from other FGC/M-affected groups and Somali groups elsewhere in the UK and beyond. There is also a need to collect more accurate evidence regarding attitudes towards FGC/M among the UK-resident population and also the experiences of healthcare providers with FGM-safeguarding provision.

**Conclusions**

Criminalised approaches and intrusive FGM-safeguarding measures are actively harming vulnerable populations. The problems affecting FGM-safeguarding in healthcare are multiple and compounding, both within particular encounters with health professionals and also across them. Unnecessary, repeated and insensitive questioning, which assume levels of dishonesty, criminality and risk, foster

distrust and fear in and ultimately disengagement from health services. Approaches to FGM-safeguarding and the demands of the FGM Enhanced Dataset have been found to directly undermine healthcare provision to FGM-affected women and families immediately and in the long term. These are not only issues for the individual health provider. The ways in which problematic statistics and assumptions underpin all policy in this area should be recognised and responded to.

The participants in our study are committed to the eradication of FGC/M. Many have already invested considerable time and energy in this endeavour. They have made recommendations to ensure the effective continuation of this work, and many are willing to work with health and other statutory services to see this realised. However, some participants have been seriously affected by existing approaches to FGM-safeguarding in Bristol. Our evidence suggests that stated government priorities to better support those who have experienced FGC/M are being undermined by their own approaches to protecting those considered at risk. This relates to both a problem with policy and also with the implementation of that policy. There is considerable work to be done by local and national health providers to repair this damage and prevent the further traumatisation and victimisation of both individual Somali families (and, potentially, those from other FGC/M-affected groups) and the community as a whole.

#### SUMMARY BOX

##### What is already known on this topic:

- Approaches to FGM-safeguarding in healthcare aim to provide effective support to those with experience of FGC/M while also protecting those at risk.
- However, there are concerns that these policies may do more harm to those from FGC/M-affected groups than good.
- To date, no academic research has been conducted to explore this in the UK.

##### What this study adds:

- This research suggests that government priorities to better support those who have experienced FGC/M are being undermined by their own approaches to protecting those considered at potential risk
- There are problems with the framing of policy and approaches to its implementation, which are based on outdated stereotypes and insensitive to the potential psychological and physical implications of FGC/M and as such risk retraumatising victims and undermining the trust of individual Somali families, and the Somali population as a whole in their healthcare providers.

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# Reporting checklist for qualitative study.

Based on the SRQR guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Page
	Reporting Item	Number
<b>Title</b>		
<a href="#">#1</a>	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	2

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Abstract

#2

Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions

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Introduction

Problem formulation

#3

Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement

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Purpose or research question

#4

Purpose of the study and specific objectives or questions

3,4

Methods

Qualitative approach and research paradigm

#5

Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability.

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As appropriate the rationale for several items might be discussed together.

Researcher characteristics and reflexivity	<a href="#">#6</a>	Researchers' characteristics that may influence the research, including personal attributes, qualifications / experience, relationship with participants, assumptions and / or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results and / or transferability	6
Context	<a href="#">#7</a>	Setting / site and salient contextual factors; rationale	5
Sampling strategy	<a href="#">#8</a>	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g. sampling saturation); rationale	5
Ethical issues pertaining to human subjects	<a href="#">#9</a>	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	5
Data collection methods	<a href="#">#10</a>	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources / methods, and modification of procedures in response to evolving study findings; rationale	5

1	Data collection	<a href="#">#11</a>	Description of instruments (e.g. interview guides,	5
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11	Units of study	<a href="#">#12</a>	Number and relevant characteristics of participants,	5
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18	Data processing	<a href="#">#13</a>	Methods for processing data prior to and during	5
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20			analysis, including transcription, data entry, data	
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31	Data analysis	<a href="#">#14</a>	Process by which inferences, themes, etc. were	5
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33			identified and developed, including the researchers	
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41	Techniques to enhance	<a href="#">#15</a>	Techniques to enhance trustworthiness and credibility	5,6
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43	trustworthiness		of data analysis (e.g. member checking, audit trail,	
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48	<b>Results/findings</b>			
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51	Syntheses and	<a href="#">#16</a>	Main findings (e.g. interpretations, inferences, and	6
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Links to empirical data	<a href="#">#17</a>	Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	6-13
<b>Discussion</b>			
Intergration with prior work, implications, transferability and contribution(s) to the field	<a href="#">#18</a>	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	6,13
Limitations	<a href="#">#19</a>	Trustworthiness and limitations of findings	13
<b>Other</b>			
Conflicts of interest	<a href="#">#20</a>	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	15
Funding	<a href="#">#21</a>	Sources of funding and other support; role of funders in data collection, interpretation and reporting	15

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# BMJ Open

## **“Putting salt on the wound”: A qualitative study of the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK.**

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**Abstract:**

**Objectives:** This research documents the experiences of people with Somali heritage with FGM-safeguarding services in healthcare and whether such services are considered appropriate by the people who encounter them.

**Design:** Six focus groups conducted with ethnic Somalis living in Bristol, during the summer of 2018, divided by gender and whether people had experienced FGM-safeguarding as adults or children.

**Setting:** Participants experienced FGM-safeguarding in primary and secondary care.

**Participants:** 30 people (21 women and 9 men), identified through local organisations or snowball sampling. All participants were of Somali heritage and aged over 18.

**Results:** Government priorities to support those who have experienced female genital cutting/mutilation (FGC/M)<sup>i</sup> are being undermined by their own approaches to protect those considered at risk. Participants argued that approaches to FGM-safeguarding were based on outdated stereotypes and inaccurate evidence which encouraged health and other service providers to see every Somali parent as a potential perpetrator of FGC/M. Female participants described providers in a range of healthcare settings, including A&E, antenatal care and general practice, as ‘fixated’ with FGC/M, which ignored both their health needs and their experience as victims themselves. Participants felt stigmatised and traumatised by their experience. This undermined their trust in health services, producing a reticence to seek care, treatment delays and reliance on alternative sources of care. Associated recommendations include developing more accurate evidence of risk, more appropriate education for healthcare providers and more collaborative approaches to FGM-safeguarding.

**Conclusions:** All the participants involved in this study are committed to the eradication of FGC/M. But the statutory approaches currently adopted to enable this are considered ill-conceived, unnecessarily heavy-handed and ultimately detrimental to this. Recognising these common aims can enable the development of services better able to protect and support those at risk of FGC/M in ways which are culturally competent and sensitive.

### Strengths and limitations of the study

- This is the first study to explore the impact on FGM-safeguarding in healthcare on users in the UK.
- The qualitative approaches adopted offer particular insights into these experiences.
- The study involves those who engage with FGM-safeguarding services in diverse ways.
- The research focuses on those with Somali heritage living in Bristol, UK.
- It does not explore the experiences or attitudes of healthcare providers.

Introduction

Female Genital Cutting/Mutilation (FGC/M)<sup>i</sup> is considered a ‘global concern’,<sup>2</sup> affecting populations from a number of African, Asian and Middle Eastern societies. Across Europe, policy responses to FGC/M have tended to criminalise those engaging in the practice.<sup>3,4</sup> In the UK, it is recognised that those living with, or at risk of, FGC/M need to be provided with sensitive and compassionate care. Patient-centred healthcare responses can ‘optimise future reproductive and sexual function, psychological health and quality of life’, while also providing an ‘effective safeguarding response’ to identify and protect those at risk.<sup>5</sup> Unfortunately, in spite of these positive aims, there are concerns that current approaches to FGM-safeguarding may instead work to stigmatise those it aims to support, directly weakening patients’ trust in health services.<sup>6</sup> To date, no academic research conducted in the UK has effectively explored this.

UK politicians and media sources have repeatedly claimed that ‘tens of thousands of girls’ living in the UK are at risk of FGM/C<sup>7-9</sup>, although the evidence available to support these statements is problematic.<sup>10</sup> The Serious Crime Act 2015 mandates that professionals in health, social care and education report to the police all girls aged under 18 who disclose or have physical evidence of FGC/M.<sup>ii,12</sup> Reporting was also introduced for monitoring purposes in general practice and mental health and acute trusts. This has been supported by the introduction of the FGM Enhanced Dataset, which requires NHS practitioners to record detailed information about FGC/M within the patient population,<sup>13,14</sup> and an information sharing system which flags the summary care records of all baby girls born to mothers who have undergone FGC/M.

Whilst these policies appear to be well-intended, concerns have been voiced regarding the evidence underpinning the policies, as well as their effectiveness.<sup>6,15</sup> For example, such policies assume a direct

<sup>i</sup> Whilst the term ‘female genital mutilation’ (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genitally mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi & Earp (2019)<sup>1</sup>. The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, scholars prefer the term, female genital cutting (FGC).

<sup>ii</sup> The WHO definition of FGM includes a range of procedures including: clitoridectomy – the partial removal of the clitoris or prepuce (type 1); excision - the partial removal of the clitoris and labia minora (type 2); infibulation – the narrowing of the vaginal opening (type 3) and; any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4 therefore includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of Type 1 and 2 also mention ‘total’ clitoral removal, but Abdulcadir et al argue that this relies on anatomically incorrect understandings of the nature of the clitoris.<sup>11</sup>

link between historical cases of FGC/M in the older, migrant generation and the risk to UK-born children despite their very different cultural environments.<sup>10</sup> There is mounting evidence that the scale of risk to UK-based children is significantly lower than these approaches presume<sup>16,17</sup>, with reduced levels of support for FGC/M particularly, but not only, among migrants and drastically fewer incidents of the most serious forms of the practice.<sup>6,18-35</sup> As Creighton and Bewley argue, “gynaecologists would see more acute complications were significant numbers really happening ‘every hour of every day’ as suggested by the 2015 Home Affairs Committee (House of Commons 2016)”.<sup>36</sup>

Identifying the scale of this risk of further complicated by non-response. By 2019, only 2% of GP practices had submitted any information to the FGM Enhanced dataset.<sup>37</sup> The reasons for this are unclear. Official explanations suggest a potential lack of awareness of reporting requirements or practical issues affecting submissions, as well as the low levels of FGC/M in certain areas.<sup>38</sup> However, we suggest that concerns about the impact of FGM-safeguarding and monitoring in healthcare on patients may also explain this. In their 2019 *BMJ* editorial, Creighton and colleagues<sup>6</sup> expressed concerns regarding the “emotional and financial weight” placed on families experiencing FGM-safeguarding. These concerns are confirmed by empirical evidence of the negative consequences of FGM-safeguarding and monitoring policies in Sweden,<sup>39</sup> which “have ramifications that are invasive and sometimes even traumatising for the girls involved... [and] may negatively influence the sexual health and rights of [the] target group.” To date, no academic study has explored these issues in the UK. This paper responds to this gap, using evidence from focus groups with Somali people living in Bristol. International statistics, including those from the World Health Organisation (WHO) and UNICEF, routinely state a 98% FGC/M prevalence rate among the Somali population, the highest in the world.<sup>40,41</sup> Consequently, those with Somali heritage have received particular scrutiny in national and international debates on FGC/M and offer a valuable focus for this study.

## Methods

The study involved six focus groups which collected data on the perspectives of Somali families with experience of FGM-safeguarding in Bristol, in the summer of 2018. Participants were identified using the research team’s existing contacts with a range of organisations run by and/or representing people with Somali heritage living in Bristol and others contacted through snowball sampling. This included those who experienced FGM-safeguarding as parents, children, significant local stakeholders and those more active as anti-FGM campaigners and those involved in the development the ‘Bristol

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Model’<sup>iii</sup>. We were approached to conduct the research by people concerned by the impact of current approaches to FGM-safeguarding in the city. However, we approached a range of organisations, including those which have historically had more involvement in FGM-safeguarding policy, to ensure that we also recruited individuals who might not be so strongly motivated to report negative experiences. This approach enabled valuable insights into the experiences of individual Somali families and also those of the Bristol Somali population more generally.

There were 30 participants in total. All participants were aged 18 or over. Focus groups were divided by age and gender to reflect the potentially varying perspectives of those who were children at the time of safeguarding and those who were adults, and participants’ stated preferences for gender-specific groups. Focus groups 1,2 and 3 included older women who described experiences of FGM-safeguarding as adults. Focus groups 4 and 5 included older men. Focus group 6 included younger women, who were children when their experiences of FGM-safeguarding occurred. All participants signed informed consent before taking part. Focus groups were conducted in the university and in community settings familiar to the participants and were recorded and transcribed by the research team. Translation was provided during focus groups by local Somali people when required. A total of thirty participants (twenty-one women and nine men) were interviewed. Ethical approval for the study was obtained from the University of Bristol Ethics Committee (Reference:K260618). While not involving medical research, this project complies with the relevant requirements of the World Medical Association Helsinki Declaration.

The research aimed to explore participants’ perspectives regarding their experience of FGM-safeguarding in different domains – health care, education, via home visits from social services and the police, in courts and at borders – and the positive and negative implications of these. Discussions also considered the direct impact of FGM-safeguarding on service engagement, and on relationships within families, the local Somali community and with wider British society. This paper focuses particularly on experiences in healthcare settings. Further details of the research are available in Karlsen et al.<sup>44</sup> Thematic analysis<sup>45</sup> identified several ways in which approaches designed to support those with experience and protect those at risk of FGC/M directly undermine the provision of effective health care. The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no important aspects of the study have been omitted; and that any discrepancies

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<sup>iii</sup> Bristol has a long traditional of pioneering work towards the development of effective FGM-safeguarding policy. Collaboration between local policy-makers, professionals from education, health, social services and the police and members of the local Somali community led to the development of the ‘Bristol Model’ of FGM-safeguarding, which was subsequently incorporated into approaches across the UK.<sup>42,43</sup>

from the study as originally planned have been explained.

### Patient and Public Involvement

No patients were involved in this study. Members of the public were involved at all stages of the research process. The research was motivated by a request from the public, and the project aims and methodology were developed in collaboration, building on mutual recognition of both the preferences of local partners and the requirements of ethical, independent research. People with a Somali heritage living in Bristol were instrumental in the identification of study participants and decisions regarding the conduct of the focus groups and provided practical support with the provision of childcare, translation and refreshments. All participants were invited to a presentation and discussion of findings with the research team prior to the publication of the report to confirm accuracy and support the maintenance of a sense of partners' ownership over the project. This approach was instrumental for minimising the impact of researcher characteristics.

### Results

FGM-safeguarding in healthcare settings was predominantly experienced by women, often in routine appointments with midwives, GPs and health visitors, although there were notable examples of FGM-safeguarding experienced in Accident and Emergency departments. While men discussed at length issues with FGM-safeguarding (both generally, and in relation to specific contexts), there was less discussion of issues with healthcare in these focus groups. This is likely to be explained by the particular ways in which Somali women engage with health care, on their own behalf when pregnant and also on behalf of their children. It is not possible to assess the frequency with which these issues occurred with these data, but certain perspectives were reiterated across multiple groups. While some participants' experiences were considered less problematic, Somali women in all focus groups discussed the negative treatment which occurred repeatedly and in each of these healthcare settings. It was considered "normal" for the mid-wife to talk about FGC/M "everyday" (at every antenatal appointment). Women in each of the focus groups explained that that an awareness that other medical concerns, particularly those relating to a woman or girl's genital area or stomach, were reacted in more extreme ways by healthcare practitioners when involving Somali people.

Several themes were evident. Most simply, most participants objected to being asked about their experiences of FGC/M. This objection was aggravated by the often-repeated nature of this questioning – across multiple or within single encounters – which was seen to ignore and even exacerbate the traumatic nature of FGC/M itself. These experiences were further worsened by approaches

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considered culturally incompetent and insensitive to, as well as ignorant of, the facts of FGC/M. Approaches to FGM-safeguarding were felt to rely on and reinforce outdated stereotypes of the Somali community, which encouraged suspicion from health providers and directly contributed to the stigmatisation and victimisation of Somali people in healthcare and more widely. All-in-all, participants argued that the focus on getting “results” for the NHS Enhanced Dataset meant that the health needs of the patient and their family were de-prioritised. The quality of the healthcare provided to Somali families had diminished as a result. Participants felt undermined and distrusted by professionals expected to care for their health and that of their families. Not surprisingly, this had negative consequences for their trust in and engagement with health services.

The re-traumatisation of FGC/M-affected women through invasive and insensitive questioning

Many of the women in the focus groups who had experienced FGC/M said it was something that they wished to forget. As well as the physical and psychological consequences of the experience, it had also damaged relationships within families which it had taken time to repair. The majority of participants felt that being asked about their experiences of FGC/M was in itself intrusive and upsetting, with one woman stating: *“This is a very private matter. You can’t just ask me what it’s like inside my legs.”* Participants objected to being asked about FGC/M when this was considered irrelevant to the health concern. But even where establishing FGC/M status might be pertinent, such as during pregnancy, participants felt that such questioning was often insensitive. That policy required these questions to be asked repeatedly aggravated women, even when they were asked sensitively. One of the issues raised most often in the focus groups was the failure of health practitioners to acknowledge that FGM-safeguarding had already been undertaken and that this information was therefore already available to them:

*“When I go to the GP, they ask me again and again, did you do that [FGC/M]? I told the GP, please write down on your computer, I don’t want to do that [FGC/M] and so please don’t ask me any more questions. I hate to hear these kinds of questions.” (Focus Group 1)*

Where participants described less distressing experiences with FGM-safeguarding in health settings, encounters had been friendly and open and participants recognised that safeguarding had been performed out of a genuine desire to protect them. This young women recounted a conversation with her GP before a holiday and described the differences between this encounter and others she had experienced:

*“She wasn’t saying it in a kinda aggressive way, she was saying it as if it was a normal chat. She*

1 goes, 'I know this is a really silly questions to ask' but she's like, 'I've gotta ask it'. She just said,  
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 3 'There isn't any chance of you having FGM done [while you're on holiday]?' I goes, 'No, there  
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 5 isn't'. She goes, 'That's fine, then.' If they were a bit more sensitive and they just kinda said, in  
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 7 a polite way, 'I don't mean to be rude or insensitive but is there any chance that your daughter  
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 9 could be at risk of FGM? No offense to you or anything', and the parent says, 'No', then...there's  
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 11 no need to get the police involved.' (Focus Group 6)  
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13 However, participants described numerous examples where health professionals had not achieved  
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 15 this:

16 "Did you have the FGM?" she [midwife] asked. It was like an interview. I was quite  
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 18 shocked.... "You have to answer this question," she told me...She was desperate to fill in  
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 20 this form. I was uncomfortable... It frightened me really." (Focus Group 1)  
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22 Participants also described how these difficult conversations could occur in quite public locations, such  
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 24 as "behind curtains, other people could hear...dignity kind of went out of the window". This reliance on  
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 26 an 'interview' style, which followed a "form" or "script", was explained as a consequence of a lack of  
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 28 understanding of FGC/M among health professionals which failed to engage with the knowledge or  
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 30 concerns of their patients: "They don't know what they are talking about. It's insulting. You feel  
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 32 embarrassed and attacked." People were embarrassed by the questions, insulted by the fact that  
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 34 health professionals knew so little about an issue they were supposedly educating them about (and  
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 36 indeed, often less than the participants themselves) and attacked by the assumptions about their  
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 38 culture which underpinned these policies and approaches. This apparent lack of care and 'interview'  
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 40 style of questioning undermined this participant's trust and sense of security in her relationship with  
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 42 her midwife, which led her to question her need for antenatal care: "I told her that I didn't need a  
 43  
 44 midwife like this".  
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46 Approaches to FGM-safeguarding in healthcare were argued to not only ignore but actually risk  
 47  
 48 exacerbating the trauma associated with the experience of FGC/M itself. Our evidence suggests that  
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 50 these traumatising effects are related to:

- 51 • the ways in which patients are forced to answer questions about their experiences of  
 52 FGC/M, even when they explicitly express a wish not to;
- 53 • the ways in which victims of FGC/M are forced to (repeatedly) disclose details of their  
 54 experience to medical staff, approaches which are generally considered inappropriate for  
 55 victims of (other forms of) child abuse; and
- 56 • the insensitive approaches which fail to acknowledge the potential psychological and  
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physical impacts of experience of FGC/M, despite these being the premise on which these policies are deemed necessary.

Taken together, these issues were considered to risk inflicting significant damage on the welfare of individuals, particularly those with experience of FGC/M:

*“The parents who had it done, they are traumatised. [...] To ask mothers who are traumatised [about FGC/M] over and over and over again. You’re putting salt on that wound, you’re making it fresh again.” (Focus Group 1)*

The impact of outdated stereotypes

Participants commented that the evidence underpinning approaches to FGM-safeguarding drew on outdated assumptions about Somali culture and the positive attitudes of people with Somali heritage towards FGC/M:

*“The minute you say there is a problem, because [of] who you are, the first thing the GP will look at you, if you mention anything about that [genital] area, any healthcare setting, they feel obliged to ask you [about FGC/M].” (Focus Group 2)*

None of the participants in our study claimed that they supported FGC/M and they all agreed that it was a practice that children should be protected from. Participants in all groups were adamant that these attitudes to FGC/M were common among British Somalis and were frustrated that this was not acknowledged in FGM-safeguarding policy: *“Young mothers, born here, do not have FGM”*. It was argued that these attitudes had been encouraged by migration to Britain, to a *“different [FGC/M] environment”*. People also described the significant impact of Bristol Somali-led anti-FGC/M initiatives on awareness of the nature and problems of FGC/M in Britain. Participants reflected that attitudes to FGC/M were changing in Somalia/Somaliland, such that even these statistics were problematic: *“A hundred years ago, this country had a different culture from today. Are the people still living in the same way? They modernised. So, in Somalia, we too modernised.”* Participants argued that they were *“trying to find our identity as British Somalis, and we don’t want FGM to be part of that”*. But approaches to FGM-safeguarding were believed to directly undermine these aims:

*“Even though, as a community, we want to move away from this practice [FGC/M], again, to be slapped across the face with it...even if communities stop practicing it, they will still be stigmatised and labelled by it, and it kind of undermines the progress that we’ve made” (Focus Group 3)*

These persistent stereotypes encouraged health practitioners to treat their patients with suspicion, misinterpreting behaviour considered normal (both for Somalis and others) as indicative of potential FGC/M risk: “[My daughter] was one of those shy kids, she wouldn’t take her clothes off in front of anybody. And the nurse kept saying to her “Do you want your mum to leave?” Approaches to FGM-safeguarding encouraged a sense of Somali parents as incompetent and prone to criminal activity: “my mum got taken for an idiot or that she was unworthy of being trusted as a parent”. Parents described how they felt forced to prove their innocence in response to the unsubstantiated negative reactions of healthcare providers. Parents were asked repeatedly about their plans to arrange FGC/M for their daughters. This was interpreted as an attempt by health practitioners to ‘catch people out’ and admit their dishonest and criminal intentions. Not surprisingly, this was considered extremely disrespectful:

*“And my mum was like, “No... no-one in my family’s had it done, I don’t know where you got this information from” and she (Nurse) kept on badgering my mum, as if she was trying to get information. Like, I know when someone tries to be manipulative, as a professional, it’s very easy, she kept asking my mum... It was very patronizing, and my mum was getting frustrated because... you know, when you see your child’s in pain and no-one’s helping them, so the more frustrated my mum got, the more angry and the more guilty it made her look...Everything got brushed aside. It was just fixated on making my mum look guilty.”*  
(Focus Group 6)

A failure to acknowledge potential changes in attitudes towards FGC/M among affected groups can exaggerate a perceived risk and encourage practitioners to view their patients with suspicion, undermining the provision of sensitive and culturally competent care. This directly contributed to participants’ loss of trust in their health providers and sense of exclusion from wider society.

### Loss of trust in health services

There was a strong sense from across the focus groups that the health needs of Somali families were being overlooked in efforts to collect data on FGC/M: “Before they cared about your health and how the child was feeling. Now it’s just FGM.” This sense of the de-prioritisation of a patient’s health needs was evident in a range of healthcare settings, including in general practice and midwifery care, as well as acute A&E services. Even those with potentially serious symptoms could have their health needs overlooked in efforts to conduct FGM-safeguarding:

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3 *"Instead of the nurse trying to figure out why I was in such pain – you know, the usual*  
4 *procedures, bloods, blood pressure, all of that – she [the A&E Nurse] skipped all those steps*  
5 *and directly, she was like to my mum, "Have you done FGM to your daughter?... I think it's*  
6 *quite dangerous when...if a nurse or a doctor hasn't been given enough training or [has]*  
7 *enough awareness on the topic to the point where they might misdiagnose the patient"*  
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11 *(Focus Group 6)*  
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14 Participants described how the Somali community – through their own educational initiatives – had  
15 become more aware of the health implications of living with FGC/M. But, even here, the focus of  
16 health providers on FGM-safeguarding and data collection meant that the health needs of women  
17 could be ignored:  
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21 *"Now there is a fear [that] she [the woman with FGC/M] will lose the child, she will have*  
22 *health problems, complications. [Somali] People are now more aware of the [long-term]*  
23 *health issues [of FGC/M]. How do we get our service providers here to understand this?"*  
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26 *(Focus Group 4)*  
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28 Such evidence further highlights the limitations of assumptions regarding the educational potential of  
29 such health provider engagement.  
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34 Participants described ways in which experiences of FGM-safeguarding had directly contributed to a  
35 loss of "confidence in the health service". Inappropriate or insensitive healthcare generated an on-  
36 going concern among families:  
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40 *"We are just very worried now. I've got a daughter who is nearly 12, if anything should*  
41 *happen to her, to her privates, if she gets an infection, the first thing that comes in my*  
42 *mind is this situation [FGM-safeguarding]. [...] It's very stressful, it keeps coming back. The*  
43 *first thing that comes in my mind is that the doctor will ask you this question."* *(Focus*  
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45  
46 *Group 1)*  
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49 There is a tangible fear relating to parents' awareness of their inability to protect their children from  
50 a system perceived to be designed to harm people. This service disengagement led some participants  
51 to rely more heavily on unregulated or unorthodox medical and non-medical alternatives, while others  
52 described engaging with health services with more reluctance and at a later stage: potentially risking  
53 their health and increasing the need for more intensive medical responses. Importantly, participants  
54 reflected that the problem with FGM-safeguarding in health care, and more generally, was as much  
55 one of legislated policy as its implementation. Health practitioners were often argued to have no  
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choice, that they were just 'doing their job': *"they feel obliged to ask you [about FGC/M] because they don't want to get in trouble"*. But while this encouraged a little sympathy for health providers, it also discouraged hope for future improvement.

### Policy recommendations

Participants in several focus groups recognised the positive intentions of FGM-safeguarding and all acknowledged the need to protect children at risk. However, approaches adopted to achieve this were believed to be unjustifiably aggressive and counter-productive, to the extent that *"Safeguarding policies [had] exacerbated and exaggerated the situation"* rather than resolving it: *"I think the safeguarding policy is fantastic, [but] you have to take precautions because...the end goal is to stop this happening, but if we are to stop this happening, we need to think about the process. If we are offending people, and to a certain extent, violating people [we will be unsuccessful]"* (Focus Group 6). The introduction of FGM-safeguarding was seen to have directly contributed to a loss of empathy in the provision of healthcare to not only individual Somali families, but the entire Somali population:

*"People are more result-orientated than [interested in] looking at the feeling and perspective of the community and parents who are involved, or even the young child who is involved. Being result-focused, it is more difficult to be empathetic with someone."*  
(Focus Group 4)

Participants argued that there were problems with the evidence underpinning these policies as well as with their implementation. People were concerned that the statistics collected as part of the FGM Enhanced Dataset, which focus on women who had experienced FGC/M as children when living outside the UK, could be *"misuse[d]"* to inflate perceptions of the scale of the FGC/M risk posed to young girls living in the UK. Participants also considered it unhelpful that the statistics collected included those for *"piercing"*, *"cosmetic [surgery]"* and *"different [less invasive] categories [of FGC/M]"*, which were less relevant for addressing what they considered to be the most pressing *"FGM issue"*. This amalgamation could also be used by the media and others to exaggerate the prevalence of FGC/M and further stigmatise the Somali population without justification. In order to get *"more accurate and precise statistics... that are not so biased"*, there was a need to *"hear the views of the young people who were born in the West."*

While some participants acknowledged the contribution of Somali people to the development of approaches to FGM-safeguarding approaches in Bristol (although attitudes regarding the longer-term

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success of this collaboration varied), others felt that the engagement of policy-makers and practitioners with Somali people in Bristol had been less than comprehensive. Recommendations for improving services therefore emphasised the need for more inclusive approaches, involving different FGC/M-affected groups, in the development and implementation of safeguarding services, with “a proper consultation” to develop “policies which we are part of”.

A constant theme among participants was the significant need to improve the education received by professionals involved in the provision of statutory FGM-safeguarding. Education was required to ensure that staff could identify and describe forms of FGC/M, and better support those who had experienced it. ‘FGM Standards for Training Healthcare Professionals’ were published in 2018,<sup>46</sup> and built on the earlier safeguarding curriculum. Training on FGC/M type is included for some, but not all, staff. Participants also described a need for more awareness of the potentially traumatic effects of FGM-safeguarding itself:

*“You gotta think about the child, as well. Imagine having to go into a hospital or doctor and get examined. Just imagine how uncomfortable you’re feeling when someone’s like searching your private parts. That’s almost like a violation to you because that’s **your** private parts... ..we have to be very considerate of the situation” (Focus group 6)*

While current guidelines expect those conducting genital examinations of children to be considerate of appropriate approaches, it is unclear whether this will be sufficient to address this. Professionals also needed training to ensure that information gathered on people’s FGC/M experience, was gathered sensitively, to avoid it being experienced as an “interrogation”:

*“It’s a relevant thing to ask [but] it’s a very sensitive thing to ask so the wording around it and how you actually approach a parent...it needs to be sorted out otherwise I feel like a lot of Somali parents are going to ... take it as an offence, instead of a general question. When you are questioning a mother about ‘are you going to send your child over there to get FGM done?’, it can come across as a threat against her culture, against her parenting. It’s like asking any parent, ‘Are you going to starve your child?’, [the reaction is] ‘Are you mocking my parenting? Why would I do that?’ That’s why I think a lot of people are very defensive”. (Focus Group 6).*

More general training to provide sensitive care and enable health providers to “be sensitive to that person’s culture” was required. More specifically, recognising “the historical [pre-migration FGC/M] context” and how that might have changed over time would also enable them “not to automatically assume that you’re guilty of this crime”. Participants argued that not only were Somali people not supportive of FGC/M, but they now understood many of the health implications of aspects of the

practice. This identified need was not recognised by health providers, and is not acknowledged in training guidelines.

Participants were particularly frustrated with the ways in which a failure to acknowledge these cultural changes encouraged mothers' experiences of FGC/M to be used as indicators of risk for their children, which unfairly framed them as potential criminals rather than victims and drew attention away from their healthcare needs. Acknowledging that not only Somali cultures were associated with FGC/M would help address the particular ways in which those with Somali heritage were "targeted". A Public Health England FGM training video which "shows that it's not just one ethnic" group was highlighted as making a positive contribution to this realisation. Developing knowledge of these "facts" was considered important for restoring a "belief in the system".

A more collaborative approach in healthcare and more generally would enable more successful interventions within families and cultural changes that could eventually lead to the elimination of FGC/M. This improved communication should also extend to establishing more effective means of responding to negative treatment: *"I think my mum did try and put in a complaint [to the NHS] but then she left it after a while because she said, 'it's not worth it if somebody's going to be uneducated. There's nothing I can do about it'".* More sensitive approaches were argued to have the potential to engage families around FGC/M while minimising the harm associated with current practices, including the sense of fear, stigmatisation, criminalisation and (re)traumatisation which is evident in current approaches:

*"If I was approached in a correct manner, I would obviously cooperate, but if I was approached in a manner where I felt targeted, harassed, I couldn't cooperate at all."*  
(Focus Group 6)

## Discussion

Global concerns regarding FGC/M and strategies developed to safeguard potential victims are premised on the potentially traumatic emotional and physical effects of these practices.<sup>47</sup> But while the need to protect potential victims is of the utmost importance, evidence from this research - while limited in its scale and generalisability - suggests that current approaches to this protection risk traumatising families, and re-traumatising child victims of FGC/M in adulthood. Such experiences undermine relationships between families and their care providers and the likelihood of effective safeguarding or indeed healthcare being provided in both FGC/M-related contexts and others. This research replicates that from Sweden, which also presents the traumatising impact of policies which

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are “meaning well while doing harm”.<sup>39</sup>

Government guidelines suggest that “adhering to key standards will enable professionals to hold conversations [on FGC/M] in a sensitive and appropriate way. These include:

- making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity;
- working with others to protect and promote the health and well-being of those in their care, their families and carers and the wider community; and
- being open and honest, acting with integrity and upholding the reputation of the profession.”<sup>48</sup>

The evidence from this research suggests that this is not happening universally. Our participants describe the ways in which their own needs and opinions were ignored and their dignity and respect undermined by a service ‘fixated’ by gathering information on FGC/M, even at times using practices considered ‘manipulative’ to achieve this. Participants’ experiences of FGM-safeguarding in healthcare directly disrupted their sense of what could be expected of their healthcare providers and, as a consequence, their trust in these services. Indeed, rather than working with families and carers, professionals were identified as sometimes working to directly undermine these relationships. We have identified a number of specific opportunities to improve services, which concur with international research on this topic.<sup>49-51</sup> It is imperative that policy-makers and healthcare providers recognise and respond to the potentially sensitive nature of FGM-safeguarding, for those with experience of FGC/M but also more generally. There is also a need to be mindful of the changing attitudes and needs of FGC/M-affected groups, and the ways in which incorrect assumptions regarding these have encouraged policies and approaches which are counter-productive and stigmatising. There is a clear need both to protect those at risk of FGC/M and support those living with its consequences and respond to evidence from this research that a perceived risk to an (often unborn) child is overriding the care of her mother, family and wider community. Further research must be conducted to determine whether similar experiences are reported amongst those from other FGC/M-affected groups and Somali groups elsewhere in the UK and beyond. There is also a need to collect more accurate evidence regarding attitudes towards FGC/M among the UK-resident population and also the experiences of healthcare providers with FGM-safeguarding provision.

## Conclusions

Criminalised approaches and intrusive FGM-safeguarding measures are actively harming vulnerable populations. The problems affecting FGM-safeguarding in healthcare are multiple and compounding, both within particular encounters with health professionals and also across them. Unnecessary, repeated and insensitive questioning, which assume levels of dishonesty, criminality and risk, foster distrust and fear in and ultimately disengagement from health services. Approaches to FGM-safeguarding and the demands of the FGM Enhanced Dataset have been found to directly undermine healthcare provision to FGM-affected women and families immediately and in the long term. These are not only issues for the individual health provider. The ways in which problematic statistics and assumptions underpin all policy in this area should be recognised and responded to.

The participants in our study are committed to the eradication of FGC/M. Many have already invested considerable time and energy in this endeavour. They have made recommendations to ensure the effective continuation of this work, and many are willing to work with health and other statutory services to see this realised. However, some participants have been seriously affected by existing approaches to FGM-safeguarding in Bristol. Our evidence suggests that stated government priorities to better support those who have experienced FGC/M are being undermined by their own approaches to protecting those considered at risk. This relates to both a problem with policy and also with the implementation of that policy. There is considerable work to be done by local and national health providers to repair this damage and prevent the further traumatisation and victimisation of both individual Somali families (and, potentially, those from other FGC/M-affected groups) and the community as a whole.

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**Contributor statement**

SK led the research project and the conception and drafting of this paper. SK, NC, MM and CP each made substantial contributions to the design and drafting of the paper. SK, NC, MM and CP collaborated on the design of the research and developing the application for funding. All authors were involved in generating data via the focus groups and analysis, interpretation and reporting of that data. All authors have provided final approval of the version published and take responsibility for the accuracy and integrity of the work.

**Competing interests**

There are no competing interests in relation to this work.

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**Data sharing statement**

No data are available.

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# Reporting checklist for qualitative study.

Based on the SRQR guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Page
Reporting Item		Number
<hr/>		
Title		
<a href="#">#1</a>	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	2

## Abstract

[#2](#) Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions

## Introduction

Problem formulation [#3](#) Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement

Purpose or research question [#4](#) Purpose of the study and specific objectives or questions

## Methods

Qualitative approach and research paradigm [#5](#) Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability.

1			As appropriate the rationale for several items might be	
2			discussed together.	
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6	Researcher	<a href="#">#6</a>	Researchers' characteristics that may influence the	7
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8	characteristics and		research, including personal attributes, qualifications /	
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10	reflexivity		experience, relationship with participants, assumptions	
11			and / or presuppositions; potential or actual interaction	
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14			transferability	
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22	Context	<a href="#">#7</a>	Setting / site and salient contextual factors; rationale	5,6
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25	Sampling strategy	<a href="#">#8</a>	How and why research participants, documents, or	5,6
26			events were selected; criteria for deciding when no	
27			further sampling was necessary (e.g. sampling	
28			saturation); rationale	
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35	Ethical issues pertaining	<a href="#">#9</a>	Documentation of approval by an appropriate ethics	6
36			review board and participant consent, or explanation	
37	to human subjects		for lack thereof; other confidentiality and data security	
38			issues	
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45	Data collection methods	<a href="#">#10</a>	Types of data collected; details of data collection	5,6
46			procedures including (as appropriate) start and stop	
47			dates of data collection and analysis, iterative process,	
48			triangulation of sources / methods, and modification of	
49			procedures in response to evolving study findings;	
50			rationale	
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1	Data collection	<a href="#">#11</a>	Description of instruments (e.g. interview guides,	6
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5	technologies		used for data collection; if / how the instruments(s)	
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7			changed over the course of the study	
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11	Units of study	<a href="#">#12</a>	Number and relevant characteristics of participants,	5-7
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13			documents, or events included in the study; level of	
14				
15			participation (could be reported in results)	
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18	Data processing	<a href="#">#13</a>	Methods for processing data prior to and during	6
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20			analysis, including transcription, data entry, data	
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22			management and security, verification of data integrity,	
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24			data coding, and anonymisation / deidentification of	
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26			excerpts	
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31	Data analysis	<a href="#">#14</a>	Process by which inferences, themes, etc. were	6,18
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33			identified and developed, including the researchers	
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35			involved in data analysis; usually references a specific	
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37			paradigm or approach; rationale	
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41	Techniques to enhance	<a href="#">#15</a>	Techniques to enhance trustworthiness and credibility	7
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43	trustworthiness		of data analysis (e.g. member checking, audit trail,	
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45			triangulation); rationale	
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48	<b>Results/findings</b>			
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51	Syntheses and	<a href="#">#16</a>	Main findings (e.g. interpretations, inferences, and	7,8
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53	interpretation		themes); might include development of a theory or	
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55			model, or integration with prior research or theory	
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1	Links to empirical data	<a href="#">#17</a>	Evidence (e.g. quotes, field notes, text excerpts,	7-15
2			photographs) to substantiate analytic findings	
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7	<b>Discussion</b>			
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10	Intergration with prior	<a href="#">#18</a>	Short summary of main findings; explanation of how	7,15
11	work, implications,		findings and conclusions connect to, support, elaborate	
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13	transferability and		on, or challenge conclusions of earlier scholarship;	
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15	contribution(s) to the field		discussion of scope of application / generalizability;	
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17			identification of unique contributions(s) to scholarship	
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19			in a discipline or field	
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24	Limitations	<a href="#">#19</a>	Trustworthiness and limitations of findings	16
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27	<b>Other</b>			
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30	Conflicts of interest	<a href="#">#20</a>	Potential sources of influence of perceived influence on	18
31			study conduct and conclusions; how these were	
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33			managed	
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38	Funding	<a href="#">#21</a>	Sources of funding and other support; role of funders in	18
39			data collection, interpretation and reporting	
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43 None The SRQR checklist is distributed with permission of Wolters Kluwer © 2014 by the Association  
44 of American Medical Colleges. This checklist can be completed online using  
45 <https://www.goodreports.org/>, a tool made by the [EQUATOR Network](#) in collaboration with  
46 [Penelope.ai](#)  
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# BMJ Open

## **"Putting salt on the wound": A qualitative study of the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK.**

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Title: "Putting salt on the wound": A qualitative study of the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK.

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**Abstract:**

**Objectives:** This research documents the experiences of people with Somali heritage with FGM-safeguarding services in healthcare and whether such services are considered appropriate by the people who encounter them.

**Design:** Six focus groups conducted with ethnic Somalis living in Bristol, during the summer of 2018, divided by gender and whether people had experienced FGM-safeguarding as adults or children.

**Setting:** Participants experienced FGM-safeguarding in primary and secondary care.

**Participants:** 30 people (21 women and 9 men), identified through local organisations or snowball sampling. All participants were of Somali heritage and aged over 18.

**Results:** Government priorities to support those who have experienced female genital cutting/mutilation (FGC/M) are being undermined by their own approaches to protect those considered at risk. Participants argued that approaches to FGM-safeguarding were based on outdated stereotypes and inaccurate evidence which encouraged health and other service providers to see every Somali parent as a potential perpetrator of FGC/M. Female participants described providers in a range of healthcare settings, including A&E, antenatal care and general practice, as ‘fixated’ with FGC/M, which ignored both their health needs and their experience as victims themselves. Participants felt stigmatised and traumatised by their experience. This undermined their trust in health services, producing a reticence to seek care, treatment delays and reliance on alternative sources of care. Associated recommendations include developing more accurate evidence of risk, more appropriate education for healthcare providers and more collaborative approaches to FGM-safeguarding.

**Conclusions:** All the participants involved in this study are committed to the eradication of FGC/M. But the statutory approaches currently adopted to enable this are considered ill-conceived, unnecessarily heavy-handed and ultimately detrimental to this. Recognising these common aims can enable the development of services better able to protect and support those at risk of FGC/M in ways which are culturally competent and sensitive.

### Strengths and limitations of the study

- This is the first study to explore the impact on FGM-safeguarding in healthcare on users in the UK.
- The qualitative approaches adopted offer particular insights into these experiences.
- The study involves those who engage with FGM-safeguarding services in diverse ways.
- The research focuses on those with Somali heritage living in Bristol, UK.
- It does not explore the experiences or attitudes of healthcare providers.

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**Introduction**

Female Genital Cutting/Mutilation (FGC/M)<sup>i</sup> is considered a ‘global concern’,<sup>2</sup> affecting populations from a number of African, Asian and Middle Eastern societies. Across Europe, policy responses to FGC/M have tended to criminalise those engaging in the practice.<sup>3,4</sup> In the UK, it is recognised that those living with, or at risk of, FGC/M need to be provided with sensitive and compassionate care. Patient-centred healthcare responses can ‘optimise future reproductive and sexual function, psychological health and quality of life’, while also providing an ‘effective safeguarding response’ to identify and protect those at risk.<sup>5</sup> Unfortunately, in spite of these positive aims, there are concerns that current approaches to FGM-safeguarding may instead work to stigmatise those it aims to support, directly weakening patients’ trust in health services.<sup>6</sup> To date, no academic research conducted in the UK has effectively explored this.

UK politicians and media sources have repeatedly claimed that ‘tens of thousands of girls’ living in the UK are at risk of FGM/C<sup>7-9</sup>, although the evidence available to support these statements is problematic.<sup>10</sup> The Serious Crime Act 2015 mandates that professionals in health, social care and education report to the police all girls aged under 18 who disclose or have physical evidence of FGC/M.<sup>ii,12</sup> Reporting was also introduced for monitoring purposes in general practice and mental health and acute trusts. This has been supported by the introduction of the FGM Enhanced Dataset, which requires NHS practitioners to record detailed information about FGC/M within the patient population,<sup>13,14</sup> and an information sharing system which flags the summary care records of all baby girls born to mothers who have undergone FGC/M.

Whilst these policies appear to be well-intended, concerns have been voiced regarding the evidence underpinning the policies, as well as their effectiveness.<sup>6,15</sup> For example, such policies assume a direct

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<sup>i</sup> Whilst the term ‘female genital mutilation’ (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genitally mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi & Earp (2019)<sup>1</sup>. The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, scholars prefer the term, female genital cutting (FGC).

<sup>ii</sup> The WHO definition of FGM includes a range of procedures including: clitoridectomy – the partial removal of the clitoris or prepuce (type 1); excision - the partial removal of the clitoris and labia minora (type 2); infibulation – the narrowing of the vaginal opening (type 3) and; any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4 therefore includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of Type 1 and 2 also mention ‘total’ clitoral removal, but Abdulcadir et al argue that this relies on anatomically incorrect understandings of the nature of the clitoris.<sup>11</sup>

link between historical cases of FGC/M in the older, migrant generation and the risk to UK-born children despite their very different cultural environments.<sup>10</sup> There is mounting evidence that the scale of risk to UK-based children is significantly lower than these approaches presume<sup>16,17</sup>, with reduced levels of support for FGC/M particularly, but not only, among migrants and drastically fewer incidents of the most serious forms of the practice.<sup>6,18-35</sup> As Creighton and Bewley argue, “gynaecologists would see more acute complications were significant numbers really happening ‘every hour of every day’ as suggested by the 2015 Home Affairs Committee (House of Commons 2016)”.<sup>36</sup>

Identifying the scale of this risk of further complicated by non-response. By 2019, only 2% of GP practices had submitted any information to the FGM Enhanced dataset.<sup>37</sup> The reasons for this are unclear. Official explanations suggest a potential lack of awareness of reporting requirements or practical issues affecting submissions, as well as the low levels of FGC/M in certain areas.<sup>38</sup> However, we suggest that concerns about the impact of FGM-safeguarding and monitoring in healthcare on patients may also explain this. In their 2019 *BMJ* editorial, Creighton and colleagues<sup>6</sup> expressed concerns regarding the “emotional and financial weight” placed on families experiencing FGM-safeguarding. These concerns are confirmed by empirical evidence of the negative consequences of FGM-safeguarding and monitoring policies in Sweden,<sup>39</sup> which “have ramifications that are invasive and sometimes even traumatising for the girls involved... [and] may negatively influence the sexual health and rights of [the] target group.” To date, no academic study has explored these issues in the UK. This paper responds to this gap, using evidence from focus groups with Somali people living in Bristol. International statistics, including those from the World Health Organisation (WHO) and UNICEF, routinely state a 98% FGC/M prevalence rate among the Somali population, the highest in the world.<sup>40,41</sup> Consequently, those with Somali heritage have received particular scrutiny in national and international debates on FGC/M and offer a valuable focus for this study.

## Methods

The study involved six focus groups which collected data on the perspectives of Somali families with experience of FGM-safeguarding in Bristol, in the summer of 2018. Our methodological approach was designed to ensure the representation of a comprehensive range of perspectives on this issue from within the Bristol Somali population. We were approached to conduct the research by people concerned by the impact of current approaches to FGM-safeguarding in the city. However, we approached a range of organisations, including those which have historically had more involvement in FGM-safeguarding policy, to ensure that we also recruited individuals who might not be so strongly

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motivated to report negative experiences. Participants were identified using the research team’s existing contacts with a range of organisations run by and/or representing people with Somali heritage living in Bristol and others contacted through snowball sampling. This included those who experienced FGM-safeguarding as parents, children, significant local stakeholders and those more active as anti-FGM campaigners and those involved in the development the ‘Bristol Model’<sup>iii</sup>. This approach enabled valuable insights into the experiences of individual Somali families and also those of the Bristol Somali population more generally. While funding constraints prevented us from reaching data saturation, there is sufficient consistency in findings across the focus groups to claim with confidence that our evidence is robust.

A total of thirty participants (twenty-one women and nine men) were interviewed. This was the maximum number of people that could be recruited within the project constraints. All participants were aged 18 or over. Focus groups were divided by age and gender to reflect the potentially varying perspectives of those who were children at the time of safeguarding and those who were adults, and participants’ stated preferences for gender-specific groups. Focus groups 1,2 and 3 included older women who described experiences of FGM-safeguarding as adults. Focus groups 4 and 5 included older men. Focus group 6 included younger women, who were children when their experiences of FGM-safeguarding occurred. All participants signed informed consent before taking part. Focus groups were conducted in the university and in community settings familiar to the participants and were recorded and transcribed by the research team. Translation was provided during focus groups by local Somali people when required. Ethical approval for the study was obtained from the University of Bristol Ethics Committee (Reference:K260618). While not involving medical research, this project complies with the relevant requirements of the World Medical Association Helsinki Declaration.

The research aimed to explore participants’ perspectives regarding their experience of FGM-safeguarding in different domains – health care, education, via home visits from social services and the police, in courts and at borders – and the positive and negative implications of these. Discussions also considered the direct impact of FGM-safeguarding on service engagement, and on relationships within families, the local Somali community and with wider British society. This paper focuses particularly on experiences in healthcare settings. Further details of the research are available in

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<sup>iii</sup> Bristol has a long traditional of pioneering work towards the development of effective FGM-safeguarding policy. Collaboration between local policy-makers, professionals from education, health, social services and the police and members of the local Somali community led to the development of the ‘Bristol Model’ of FGM-safeguarding, which was subsequently incorporated into approaches across the UK.<sup>42,43</sup>

Karlsen et al.<sup>44</sup> Thematic analysis<sup>45</sup> identified several ways in which approaches designed to support those with experience and protect those at risk of FGC/M directly undermine the provision of effective health care. The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no important aspects of the study have been omitted; and that any discrepancies from the study as originally planned have been explained.

### **Patient and Public Involvement**

No patients were involved in this study. Members of the public were involved at all stages of the research process. The research was motivated by a request from the public, and the project aims and methodology were developed in collaboration, building on mutual recognition of both the preferences of local partners and the requirements of ethical, independent research. People with a Somali heritage living in Bristol were instrumental in the identification of study participants and decisions regarding the conduct of the focus groups and provided practical support with the provision of childcare, translation and refreshments. All participants were invited to a presentation and discussion of findings with the research team prior to the publication of the report to confirm accuracy and support the maintenance of a sense of partners' ownership over the project. This approach was instrumental for minimising the impact of researcher characteristics.

### **Results**

FGM-safeguarding in healthcare settings was predominantly experienced by women, often in routine appointments with midwives, GPs and health visitors, although there were notable examples of FGM-safeguarding experienced in Accident and Emergency departments. While men discussed at length issues with FGM-safeguarding (both generally, and in relation to specific contexts), there was less discussion of issues with healthcare in these focus groups. This is likely to be explained by the particular ways in which Somali women engage with health care, on their own behalf when pregnant and also on behalf of their children. It is not possible to assess the frequency with which these issues occurred with these data, but certain perspectives were reiterated across multiple groups. While some participants' experiences were considered less problematic, Somali women in all focus groups discussed the negative treatment which occurred repeatedly and in each of these healthcare settings. It was considered "normal" for the mid-wife to talk about FGC/M "everyday" (at every antenatal appointment). Women in each of the focus groups explained that that an awareness that other medical concerns, particularly those relating to a woman or girl's genital area or stomach, were reacted in more extreme ways by healthcare practitioners when involving Somali people.

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Several themes were evident. Most simply, most participants objected to being asked about their experiences of FGC/M. This objection was aggravated by the often-repeated nature of this questioning – across multiple or within single encounters – which was seen to ignore and even exacerbate the traumatic nature of FGC/M itself. These experiences were further worsened by approaches considered culturally incompetent and insensitive to, as well as ignorant of, the facts of FGC/M. Approaches to FGM-safeguarding were felt to rely on and reinforce outdated stereotypes of the Somali community, which encouraged suspicion from health providers and directly contributed to the stigmatisation and victimisation of Somali people in healthcare and more widely. All-in-all, participants argued that the focus on getting “results” for the NHS Enhanced Dataset meant that the health needs of the patient and their family were de-prioritised. The quality of the healthcare provided to Somali families had diminished as a result. Participants felt undermined and distrusted by professionals expected to care for their health and that of their families. Not surprisingly, this had negative consequences for their trust in and engagement with health services.

The re-traumatisation of FGC/M-affected women through invasive and insensitive questioning

Many of the women in the focus groups who had experienced FGC/M said it was something that they wished to forget. As well as the physical and psychological consequences of the experience, it had also damaged relationships within families which it had taken time to repair. The majority of participants felt that being asked about their experiences of FGC/M was in itself intrusive and upsetting, with one woman stating: “This is a very private matter. You can’t just ask me what it’s like inside my legs.” Participants objected to being asked about FGC/M when this was considered irrelevant to the health concern. But even where establishing FGC/M status might be pertinent, such as during pregnancy, participants felt that such questioning was often insensitive. That policy required these questions to be asked repeatedly aggravated women, even when they were asked sensitively. One of the issues raised most often in the focus groups was the failure of health practitioners to acknowledge that FGM-safeguarding had already been undertaken and that this information was therefore already available to them:

*“When I go to the GP, they ask me again and again, did you do that [FGC/M]? I told the GP, please write down on your computer, I don’t want to do that [FGC/M] and so please don’t ask me any more questions. I hate to hear these kinds of questions.” (Focus Group 1)*

Where participants described less distressing experiences with FGM-safeguarding in health settings, encounters had been friendly and open and participants recognised that safeguarding had been

performed out of a genuine desire to protect them. This young women recounted a conversation with her GP before a holiday and described the differences between this encounter and others she had experienced:

*"She wasn't saying it in a kinda aggressive way, she was saying it as if it was a normal chat. She goes, 'I know this is a really silly questions to ask' but she's like, 'I've gotta ask it'. She just said, 'There isn't any chance of you having FGM done [while you're on holiday]?' I goes, 'No, there isn't'. She goes, 'That's fine, then.' If they were a bit more sensitive and they just kinda said, in a polite way, 'I don't mean to be rude or insensitive but is there any chance that your daughter could be at risk of FGM? No offense to you or anything', and the parent says, 'No', then...there's no need to get the police involved."* (Focus Group 6)

However, participants described numerous examples where health professionals had not achieved this:

*"Did you have the FGM?" she [midwife] asked. It was like an interview. I was quite shocked.... "You have to answer this question," she told me...She was desperate to fill in this form. I was uncomfortable... It frightened me really."* (Focus Group 1)

Participants also described how these difficult conversations could occur in quite public locations, such as *"behind curtains, other people could hear...dignity kind of went out of the window"*. This reliance on an 'interview' style, which followed a *"form"* or *"script"*, was explained as a consequence of a lack of understanding of FGC/M among health professionals which failed to engage with the knowledge or concerns of their patients: *"They don't know what they are talking about. It's insulting. You feel embarrassed and attacked."* People were embarrassed by the questions, insulted by the fact that health professionals knew so little about an issue they were supposedly educating them about (and indeed, often less than the participants themselves) and attacked by the assumptions about their culture which underpinned these policies and approaches. This apparent lack of care and 'interview' style of questioning undermined this participant's trust and sense of security in her relationship with her midwife, which led her to question her need for antenatal care: *"I told her that I didn't need a midwife like this"*.

Approaches to FGM-safeguarding in healthcare were argued to not only ignore but actually risk exacerbating the trauma associated with the experience of FGC/M itself. Our evidence suggests that these traumatising effects are related to:

- the ways in which patients are forced to answer questions about their experiences of FGC/M, even when they explicitly express a wish not to;

- the ways in which victims of FGC/M are forced to (repeatedly) disclose details of their experience to medical staff, approaches which are generally considered inappropriate for victims of (other forms of) child abuse; and
- the insensitive approaches which fail to acknowledge the potential psychological and physical impacts of experience of FGC/M, despite these being the premise on which these policies are deemed necessary.

Taken together, these issues were considered to risk inflicting significant damage on the welfare of individuals, particularly those with experience of FGC/M:

*“The parents who had it done, they are traumatised. [...] To ask mothers who are traumatised [about FGC/M] over and over and over again. You’re putting salt on that wound, you’re making it fresh again.” (Focus Group 1)*

#### The impact of outdated stereotypes

Participants commented that the evidence underpinning approaches to FGM-safeguarding drew on outdated assumptions about Somali culture and the positive attitudes of people with Somali heritage towards FGC/M:

*“The minute you say there is a problem, because [of] who you are, the first thing the GP will look at you, if you mention anything about that [genital] area, any healthcare setting, they feel obliged to ask you [about FGC/M].” (Focus Group 2)*

None of the participants in our study claimed that they supported FGC/M and they all agreed that it was a practice that children should be protected from. Participants in all groups were adamant that these attitudes to FGC/M were common among British Somalis and were frustrated that this was not acknowledged in FGM-safeguarding policy: *“Young mothers, born here, do not have FGM”*. It was argued that these attitudes had been encouraged by migration to Britain, to a *“different [FGC/M] environment”*. People also described the significant impact of Bristol Somali-led anti-FGC/M initiatives on awareness of the nature and problems of FGC/M in Britain. Participants reflected that attitudes to FGC/M were changing in Somalia/Somaliland, such that even these statistics were problematic: *“A hundred years ago, this country had a different culture from today. Are the people still living in the same way? They modernised. So, in Somalia, we too modernised.”* Participants argued that they were *“trying to find our identity as British Somalis, and we don’t want FGM to be part of that”*. But approaches to FGM-safeguarding were believed to directly undermine these aims:

*“Even though, as a community, we want to move away from this practice [FGC/M], again,*

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3 *to be slapped across the face with it...even if communities stop practicing it, they will still*  
4 *be stigmatised and labelled by it, and it kind of undermines the progress that we've made"*  
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6 *(Focus Group 3)*  
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11 These persistent stereotypes encouraged health practitioners to treat their patients with suspicion,  
12 misinterpreting behaviour considered normal (both for Somalis and others) as indicative of potential  
13 FGC/M risk: "[My daughter] was one of those shy kids, she wouldn't take her clothes off in front of  
14 anybody. And the nurse kept saying to her "Do you want your mum to leave?" Approaches to FGM-  
15 safeguarding encouraged a sense of Somali parents as incompetent and prone to criminal activity:  
16 "my mum got taken for an idiot or that she was unworthy of being trusted as a parent". Parents  
17 described how they felt forced to prove their innocence in response to the unsubstantiated negative  
18 reactions of healthcare providers. Parents were asked repeatedly about their plans to arrange FGC/M  
19 for their daughters. This was interpreted as an attempt by health practitioners to 'catch people out'  
20 and admit their dishonest and criminal intentions. Not surprisingly, this was considered extremely  
21 disrespectful:  
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25 *"And my mum was like, "No... no-one in my family's had it done, I don't know where you*  
26 *got this information from" and she (Nurse) kept on badgering my mum, as if she was trying*  
27 *to get information. Like, I know when someone tries to be manipulative, as a professional,*  
28 *it's very easy, she kept asking my mum... It was very patronizing, and my mum was getting*  
29 *frustrated because... you know, when you see your child's in pain and no-one's helping*  
30 *them, so the more frustrated my mum got, the more angry and the more guilty it made*  
31 *her look...Everything got brushed aside. It was just fixated on making my mum look guilty."*  
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33 *(Focus Group 6)*  
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45 A failure to acknowledge potential changes in attitudes towards FGC/M among affected groups can  
46 exaggerate a perceived risk and encourage practitioners to view their patients with suspicion,  
47 undermining the provision of sensitive and culturally competent care. This directly contributed to  
48 participants' loss of trust in their health providers and sense of exclusion from wider society.  
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## 55 Loss of trust in health services

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57 There was a strong sense from across the focus groups that the health needs of Somali families were  
58 being overlooked in efforts to collect data on FGC/M: "Before they cared about your health and how  
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*the child was feeling. Now it's just FGM.*" This sense of the de-prioritisation of a patient's health needs was evident in a range of healthcare settings, including in general practice and midwifery care, as well as acute A&E services. Even those with potentially serious symptoms could have their health needs overlooked in efforts to conduct FGM-safeguarding:

*"Instead of the nurse trying to figure out why I was in such pain – you know, the usual procedures, bloods, blood pressure, all of that – she [the A&E Nurse] skipped all those steps and directly, she was like to my mum, "Have you done FGM to your daughter?... I think it's quite dangerous when...if a nurse or a doctor hasn't been given enough training or [has] enough awareness on the topic to the point where they might misdiagnose the patient"*  
(Focus Group 6)

Participants described how the Somali community – through their own educational initiatives – had become more aware of the health implications of living with FGC/M. But, even here, the focus of health providers on FGM-safeguarding and data collection meant that the health needs of women could be ignored:

*"Now there is a fear [that] she [the woman with FGC/M] will lose the child, she will have health problems, complications. [Somali] People are now more aware of the [long-term] health issues [of FGC/M]. How do we get our service providers here to understand this?"*  
(Focus Group 4)

Such evidence further highlights the limitations of assumptions regarding the educational potential of such health provider engagement.

Participants described ways in which experiences of FGM-safeguarding had directly contributed to a loss of *"confidence in the health service"*. Inappropriate or insensitive healthcare generated an on-going concern among families:

*"We are just very worried now. I've got a daughter who is nearly 12, if anything should happen to her, to her privates, if she gets an infection, the first thing that comes in my mind is this situation [FGM-safeguarding]. [...] It's very stressful, it keeps coming back. The first thing that comes in my mind is that the doctor will ask you this question."* (Focus Group 1)

There is a tangible fear relating to parents' awareness of their inability to protect their children from a system perceived to be designed to harm people. This service disengagement led some participants to rely more heavily on unregulated or unorthodox medical and non-medical alternatives, while others

described engaging with health services with more reluctance and at a later stage: potentially risking their health and increasing the need for more intensive medical responses. Importantly, participants reflected that the problem with FGM-safeguarding in health care, and more generally, was as much one of legislated policy as its implementation. Health practitioners were often argued to have no choice, that they were just 'doing their job': *"they feel obliged to ask you [about FGC/M] because they don't want to get in trouble"*. But while this encouraged a little sympathy for health providers, it also discouraged hope for future improvement.

### Policy recommendations

Participants in several focus groups recognised the positive intentions of FGM-safeguarding and all acknowledged the need to protect children at risk. However, approaches adopted to achieve this were believed to be unjustifiably aggressive and counter-productive, to the extent that *"Safeguarding policies [had] exacerbated and exaggerated the situation"* rather than resolving it: *"I think the safeguarding policy is fantastic, [but] you have to take precautions because...the end goal is to stop this happening, but if we are to stop this happening, we need to think about the process. If we are offending people, and to a certain extent, violating people [we will be unsuccessful]"* (Focus Group 6). The introduction of FGM-safeguarding was seen to have directly contributed to a loss of empathy in the provision of healthcare to not only individual Somali families, but the entire Somali population:

*"People are more result-orientated than [interested in] looking at the feeling and perspective of the community and parents who are involved, or even the young child who is involved. Being result-focused, it is more difficult to be empathetic with someone."*  
(Focus Group 4)

Participants argued that there were problems with the evidence underpinning these policies as well as with their implementation. People were concerned that the statistics collected as part of the FGM Enhanced Dataset, which focus on women who had experienced FGC/M as children when living outside the UK, could be *"misuse[d]"* to inflate perceptions of the scale of the FGC/M risk posed to young girls living in the UK. Participants also considered it unhelpful that the statistics collected included those for *"piercing"*, *"cosmetic [surgery]"* and *"different [less invasive] categories [of FGC/M]"*, which were less relevant for addressing what they considered to be the most pressing *"FGM issue"*. This amalgamation could also be used by the media and others to exaggerate the prevalence of FGC/M and further stigmatise the Somali population without justification. In order to get *"more*

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*accurate and precise statistics... that are not so biased”, there was a need to “hear the views of the young people who were born in the West.”*

While some participants acknowledged the contribution of Somali people to the development of approaches to FGM-safeguarding approaches in Bristol (although attitudes regarding the longer-term success of this collaboration varied), others felt that the engagement of policy-makers and practitioners with Somali people in Bristol had been less than comprehensive. Recommendations for improving services therefore emphasised the need for more inclusive approaches, involving different FGC/M-affected groups, in the development and implementation of safeguarding services, with *“a proper consultation”* to develop *“policies which we are part of”*.

A constant theme among participants was the significant need to improve the education received by professionals involved in the provision of statutory FGM-safeguarding. Education was required to ensure that staff could identify and describe forms of FGC/M, and better support those who had experienced it. ‘FGM Standards for Training Healthcare Professionals’ were published in 2018,<sup>46</sup> and built on the earlier safeguarding curriculum. Training on FGC/M type is included for some, but not all, staff. Participants also described a need for more awareness of the potentially traumatic effects of FGM-safeguarding itself:

*“You gotta think about the child, as well. Imagine having to go into a hospital or doctor and get examined. Just imagine how uncomfortable you’re feeling when someone’s like searching your private parts. That’s almost like a violation to you because that’s **your** private parts... ..we have to be very considerate of the situation” (Focus group 6)*

While current guidelines expect those conducting genital examinations of children to be considerate of appropriate approaches, it is unclear whether this will be sufficient to address this. Professionals also needed training to ensure that information gathered on people’s FGC/M experience, was gathered sensitively, to avoid it being experienced as an *“interrogation”*:

*“It’s a relevant thing to ask [but] it’s a very sensitive thing to ask so the wording around it and how you actually approach a parent...it needs to be sorted out otherwise I feel like a lot of Somali parents are going to ... take it as an offence, instead of a general question. When you are questioning a mother about ‘are you going to send your child over there to get FGM done?’, it can come across as a threat against her culture, against her parenting. It’s like asking any parent, ‘Are you going to starve your child?’, [the reaction is] ‘Are you mocking my parenting? Why would I do that?’ That’s why I think a lot of people are very defensive”. (Focus Group 6).*

More general training to provide sensitive care and enable health providers to *“be sensitive to that*

person's culture" was required. More specifically, recognising "the historical [pre-migration FGC/M] context" and how that might have changed over time would also enable them "not to automatically assume that you're guilty of this crime". Participants argued that not only were Somali people not supportive of FGC/M, but they now understood many of the health implications of aspects of the practice. This identified need was not recognised by health providers, and is not acknowledged in training guidelines.

Participants were particularly frustrated with the ways in which a failure to acknowledge these cultural changes encouraged mothers' experiences of FGC/M to be used as indicators of risk for their children, which unfairly framed them as potential criminals rather than victims and drew attention away from their healthcare needs. Acknowledging that not only Somali cultures were associated with FGC/M would help address the particular ways in which those with Somali heritage were "targeted". A Public Health England FGM training video which "shows that it's not just one ethnic" group was highlighted as making a positive contribution to this realisation. Developing knowledge of these "facts" was considered important for restoring a "belief in the system".

A more collaborative approach in healthcare and more generally would enable more successful interventions within families and cultural changes that could eventually lead to the elimination of FGC/M. This improved communication should also extend to establishing more effective means of responding to negative treatment: "I think my mum did try and put in a complaint [to the NHS] but then she left it after a while because she said, "it's not worth it if somebody's going to be uneducated. There's nothing I can do about it". More sensitive approaches were argued to have the potential to engage families around FGC/M while minimising the harm associated with current practices, including the sense of fear, stigmatisation, criminalisation and (re)traumatisation which is evident in current approaches:

*"If I was approached in a correct manner, I would obviously cooperate, but if I was approached in a manner where I felt targeted, harassed, I couldn't cooperate at all."*  
(Focus Group 6)

## Discussion

Global concerns regarding FGC/M and strategies developed to safeguard potential victims are premised on the potentially traumatic emotional and physical effects of these practices.<sup>47</sup> But while the need to protect potential victims is of the utmost importance, evidence from this research - while limited in its scale and generalisability - suggests that current approaches to this protection risk

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traumatising families, and re-traumatising child victims of FGC/M in adulthood. Such experiences undermine relationships between families and their care providers and the likelihood of effective safeguarding or indeed healthcare being provided in both FGC/M-related contexts and others. This research replicates that from Sweden, which also presents the traumatising impact of policies which are “meaning well while doing harm”.<sup>39</sup>

Government guidelines suggest that “adhering to key standards will enable professionals to hold conversations [on FGC/M] in a sensitive and appropriate way. These include:

- making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity;
- working with others to protect and promote the health and well-being of those in their care, their families and carers and the wider community; and
- being open and honest, acting with integrity and upholding the reputation of the profession.”<sup>48</sup>

The evidence from this research suggests that this is not happening universally. Our participants describe the ways in which their own needs and opinions were ignored and their dignity and respect undermined by a service ‘fixated’ by gathering information on FGC/M, even at times using practices considered ‘manipulative’ to achieve this. Participants’ experiences of FGM-safeguarding in healthcare directly disrupted their sense of what could be expected of their healthcare providers and, as a consequence, their trust in these services. Indeed, rather than working with families and carers, professionals were identified as sometimes working to directly undermine these relationships. We have identified a number of specific opportunities to improve services, which concur with international research on this topic.<sup>49-51</sup> It is imperative that policy-makers and healthcare providers recognise and respond to the potentially sensitive nature of FGM-safeguarding, for those with experience of FGC/M but also more generally. There is also a need to be mindful of the changing attitudes and needs of FGC/M-affected groups, and the ways in which incorrect assumptions regarding these have encouraged policies and approaches which are counter-productive and stigmatising. There is a clear need both to protect those at risk of FGC/M and support those living with its consequences and respond to evidence from this research that a perceived risk to an (often unborn) child is overriding the care of her mother, family and wider community. Further research must be conducted to determine whether similar experiences are reported amongst those from other FGC/M-affected groups and Somali groups elsewhere in the UK and beyond. There is also a need to collect more accurate evidence regarding attitudes towards FGC/M among the UK-resident population and also the experiences of healthcare providers with FGM-safeguarding provision.

For peer review only

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**Conclusions**

Criminalised approaches and intrusive FGM-safeguarding measures are actively harming vulnerable populations. The problems affecting FGM-safeguarding in healthcare are multiple and compounding, both within particular encounters with health professionals and also across them. Unnecessary, repeated and insensitive questioning, which assume levels of dishonesty, criminality and risk, foster distrust and fear in and ultimately disengagement from health services. Approaches to FGM-safeguarding and the demands of the FGM Enhanced Dataset have been found to directly undermine healthcare provision to FGM-affected women and families immediately and in the long term. These are not only issues for the individual health provider. The ways in which problematic statistics and assumptions underpin all policy in this area should be recognised and responded to.

The participants in our study are committed to the eradication of FGC/M. Many have already invested considerable time and energy in this endeavour. They have made recommendations to ensure the effective continuation of this work, and many are willing to work with health and other statutory services to see this realised. However, some participants have been seriously affected by existing approaches to FGM-safeguarding in Bristol. Our evidence suggests that stated government priorities to better support those who have experienced FGC/M are being undermined by their own approaches to protecting those considered at risk. This relates to both a problem with policy and also with the implementation of that policy. There is considerable work to be done by local and national health providers to repair this damage and prevent the further traumatisation and victimisation of both individual Somali families (and, potentially, those from other FGC/M-affected groups) and the community as a whole.

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## Contributor statement

SK led the research project and the conception and drafting of this paper. SK, NC, MM and CP each made substantial contributions to the design and drafting of the paper. SK, NC, MM and CP collaborated on the design of the research and developing the application for funding. All authors were involved in generating data via the focus groups and analysis, interpretation and reporting of that data. All authors have provided final approval of the version published and take responsibility for the accuracy and integrity of the work.

## Competing interests

There are no competing interests in relation to this work.

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## Data sharing statement

No data are available.

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# Reporting checklist for qualitative study.

Based on the SRQR guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Page
	Reporting Item	Number
<b>Title</b>		
<a href="#">#1</a>	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	2

1	<b>Abstract</b>			
2				
3				
4		<a href="#">#2</a>	Summary of the key elements of the study using the	2
5			abstract format of the intended publication; typically	
6			includes background, purpose, methods, results and	
7			conclusions	
8				
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13				
14	<b>Introduction</b>			
15				
16				
17	Problem formulation	<a href="#">#3</a>	Description and significance of the problem /	3,4
18			phenomenon studied: review of relevant theory and	
19			empirical work; problem statement	
20				
21				
22				
23				
24				
25	Purpose or research	<a href="#">#4</a>	Purpose of the study and specific objectives or	4,5
26	question		questions	
27				
28				
29				
30	<b>Methods</b>			
31				
32				
33	Qualitative approach and	<a href="#">#5</a>	Qualitative approach (e.g. ethnography, grounded	6
34	research paradigm		theory, case study, phenomenology, narrative research)	
35			and guiding theory if appropriate; identifying the	
36			research paradigm (e.g. postpositivist, constructivist /	
37			interpretivist) is also recommended; rationale. The	
38			rationale should briefly discuss the justification for	
39			choosing that theory, approach, method or technique	
40			rather than other options available; the assumptions	
41			and limitations implicit in those choices and how those	
42			choices influence study conclusions and transferability.	
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As appropriate the rationale for several items might be discussed together.

Researcher characteristics and reflexivity	<a href="#">#6</a>	Researchers' characteristics that may influence the research, including personal attributes, qualifications / experience, relationship with participants, assumptions and / or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results and / or transferability	7
Context	<a href="#">#7</a>	Setting / site and salient contextual factors; rationale	5,6
Sampling strategy	<a href="#">#8</a>	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g. sampling saturation); rationale	5,6
Ethical issues pertaining to human subjects	<a href="#">#9</a>	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	6
Data collection methods	<a href="#">#10</a>	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources / methods, and modification of procedures in response to evolving study findings; rationale	5,6

1	Data collection	<a href="#">#11</a>	Description of instruments (e.g. interview guides,	6
2				
3	instruments and		questionnaires) and devices (e.g. audio recorders)	
4				
5	technologies		used for data collection; if / how the instruments(s)	
6				
7			changed over the course of the study	
8				
9				
10				
11	Units of study	<a href="#">#12</a>	Number and relevant characteristics of participants,	5-7
12				
13			documents, or events included in the study; level of	
14				
15			participation (could be reported in results)	
16				
17				
18	Data processing	<a href="#">#13</a>	Methods for processing data prior to and during	6
19				
20			analysis, including transcription, data entry, data	
21				
22			management and security, verification of data integrity,	
23				
24			data coding, and anonymisation / deidentification of	
25				
26			excerpts	
27				
28				
29				
30				
31	Data analysis	<a href="#">#14</a>	Process by which inferences, themes, etc. were	6,18
32				
33			identified and developed, including the researchers	
34				
35			involved in data analysis; usually references a specific	
36				
37			paradigm or approach; rationale	
38				
39				
40				
41	Techniques to enhance	<a href="#">#15</a>	Techniques to enhance trustworthiness and credibility	7
42				
43	trustworthiness		of data analysis (e.g. member checking, audit trail,	
44				
45			triangulation); rationale	
46				
47				
48	<b>Results/findings</b>			
49				
50				
51	Syntheses and	<a href="#">#16</a>	Main findings (e.g. interpretations, inferences, and	7,8
52				
53	interpretation		themes); might include development of a theory or	
54				
55			model, or integration with prior research or theory	
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Links to empirical data	<a href="#">#17</a>	Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	7-15
<b>Discussion</b>			
Intergration with prior work, implications, transferability and contribution(s) to the field	<a href="#">#18</a>	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	7,15
Limitations	<a href="#">#19</a>	Trustworthiness and limitations of findings	16
<b>Other</b>			
Conflicts of interest	<a href="#">#20</a>	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	18
Funding	<a href="#">#21</a>	Sources of funding and other support; role of funders in data collection, interpretation and reporting	18

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